Latin American social medicine the making of a thought style

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LATIN AMERICAN SOCIAL MEDICINE

THE MAKING OF A THOUGHT STYLE

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ABBREVIATIONS:

- **ABRASCO** Associação Brasileira de Saúde Coletiva. Collective Health Brazilian Association.
- **ALAMES** Asociación Latinoamericana de Medicina Social. Latin American Social Medicine Association.
- **CEAS** Centro de Estudios y Asesoria en Salud. Health Research and Advisory Centre.
- **CEBES** Centro Brasileiro de Estudos de Saude. Brazilian Centre for Health Studies.
- **CEPAL** Comisión Económica para America Latina y el Caribe. United Nations Economic Commission for Latin America and the Caribbean.
- **CESS** Centro de Estudio Sanitarios y Sociales. Centre for Sanitary and Social Studies.
- **CLACSO** Consejo Latinoamericano de Ciencias Sociales. Latin American Council of Social Sciences.
- **CUS** Cobertura Universal en Salud. Universal Healthcare Coverage.
- **FLACSO** Facultad Latinoamericana de Ciencias Sociales. Latin American Faculty of Social Sciences.
- **FMLN** Frente Farabundo Marti de Liberacion Nacional. Liberation Army Farabundo Marti.
- **HDP** Health and Disease Process.
- **HMM** Hegemonic Medical Model.
- **HRH** Human Right to Health.
- **IAHP** International Association of Health Policy.
- **IMF** International Monetary Fund.
- **MbF** Milbank Foundation.
- **MSSC** Medicina Social y Salud Colectiva. Social Medicine and Collective Health in Latin America.
- **RED-LOMSODES** Red Latinoamericana de Organizaciones y Movimientos Sociales por el Derecho a la Salud. Latin American Network of Social Movements for the Human Right to Health.
- **RF** Rockefeller Foundation.
- **PHM** People's Health Movement.
- **SDH** Social Determinants of Health.
- **SDm** Social Determination model
- **SUS** Sistema Unico de Saude. Unified Healthcare System.
- **UAM-X** Universidad Autonoma Metropolitana in Xochimilco. Metropolitan Autonomous University at Xochimilco, México D.F., México.
- **UERJ** Universidad Estadual do Rio de Janeiro. State University of Rio de Janeiro, Rio de Janeiro, Brazil.
- **UNDP** United Nations Development Program.
- **WB** World Bank.
- **WHO** World Health Organization.
- **WTO** World Trade Organization.

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CHAPTER 1

LATIN AMERICAN SOCIAL MEDICINE: THE MAKING OF A THOUGHT STYLE

I. INTRODUCTION:

"The collective health movement is a determined effort to see beyond the horizon of conventional public health. It is a deep vocation to transform our societies in line with principles of life and care. The collective health movement is a socio-political militancy…an attempt to build subjects that work towards the awakening of individualities and the construction of citizens…It is to seek the advancement of health science to enhance the development of population health and happiness, as well as to reduce suffering and control diseases."

- **Jairnilson da Silva Paim, Argentinian physician, public health scholar and Professor of Health Policy at the Institute of Collective Health, the public Universidade Federal da Bahia in Brazil, 2017.**

For those engaged in the theories and practices of collective health and social medicine, it is clear this approach does not merely seek to improve public health, but also aims at a profound transformation on how health is understood in contemporary societies. As a medical doctor who trained and practised in Latin America, my experience of delving into social medicine has challenged the foundational ideas I held throughout my professional career. Collective health and social medicine have indeed 'awakened' a commitment to take a multidisciplinary approach to research that population health and disease demands. Indeed, the study of social medicine as a situated way of thinking about health in Latin America comes at a critical time, with the SARS-CoV-2/COVID19 crisis laying bare the need to reimagine the intersection between social sciences, medical humanities, and healthcare practices.

The COVID crisis has led to a renewed interest in local knowledge and situated ways of applying reasoning to health in unprecedented ways. Such epistemologies take contextual values, priorities, claims and needs seriously, to vindicate the sufferings and struggles of people in ways that managerial and technocratic biomedicine cannot. The study of positioned standpoints is relevant to global health because situated epistemologies shed a unique light on power asymmetries, systematic oppression and social injustices that stem from the embodied experiences of subjugated groups. This thesis, therefore, answers critical questions about the integration of social medicine perspectives into global health debates, mainly, how do we begin to think about situated and non-dominant ways of thinking health and disease? The question is elaborated in this thesis by focusing on a prominent case of local knowledge and situated way of thinking from Latin America: the *Asociación Latinoamericana de Medicina Social* (ALAMES or Latin American Social Medicine Association). This research addresses two specific questions about the ALAMES collective: how does Latin American social medicine understand contemporary health and disease, and how has this way of reasoning health been articulated and elaborated over time?

Contemporary social medicine is a field of research grounded in the fundamental observation that health and disease cannot be understood exclusively in biological terms. Common concerns in the literature include the causal mechanisms of health inequalities, the epistemology of health research, the politics of global health, and the social history of medicine (Anderson, 2009, 2014; Harding, 2011; Geissler and Molyneux, 2017). Social medicine's interdisciplinary approach has a long Euro-American tradition, emerging from the nineteenth and twentieth-century scholars including *Louis-René Villermé* (France), Rudolph Virchow (Germany), John Ryle (UK), and Henry Ernest Sigerist (US). Since then, social medicine scholars recognise that the rationale and practices of health are embedded in a particular context and, as a result, their research integrates various social science disciplines including anthropology, sociology, history, and geography.

The objections to understanding health strictly in biological terms were already on the rise before the pandemic, mainly stemming from the social determinants of health and social epidemiology literature (Marmot et al., 2012; Kawachi et al., 2014; Marmot, 2015a, b). Several views, such as the psychosocial theory, fundamental cause theory, and social gradient theory of health, point to the need for a more comprehensive understanding of the social basis of health. Rather than dismissing evidence, the challenges to the universality of biomedical knowledge involves questioning the

privileged status this way of reasoning health and disease tends to have in scientific epistemology worldwide. From the standpoint of situated epistemologies, the denial of the context in biomedical research make its claims to objectivity, impartiality and universality an 'illusory' attempt to self-adjudicate totalitarian authority over knowledge in science (Haraway, 1988; Harding, 1991; Grasswick, 2018; Anderson, 2020).

Hence, this doctoral research is interested in non-dominant and situated ways of thinking about the social basis of health and disease emerging from social medicine, that is, in its specificity across different contexts of the globe. Although the study of these situated approaches are undoubtedly relevant to the social sciences of health, context-sensitive, locally-informed and historically-situated research are still a work in progress (Lakoff, 2005; Reubi, 2009a; Lock and Nguyen, 2010; Patel, 2014; Mills, 2014; Peckham and Pomfert, 2013; Vieira-da-Silva and Pinell, 2014). In addition, the published material continues to be mostly Euro-American, prompting an urgency to analyse the long-neglected contributions of other standpoints emerging from Latin America, Asia and Africa.

The analysis presented in this thesis addresses the gap of knowledge on local perspectives by critically analysing the content and trajectory of social medicine in Latin America as an alternative and particularised form of thinking about health and disease. ALAMES, the social medicine collective that integrates the largest number of Latin American countries and universities, is not only a body of knowledge that challenges dominant health epistemologies, but also an episteme whose influence shapes the course of health debates in the region. By focusing on the local character of Latin American social medicine, this thesis suggests that ALAMES generates a contextualised way of approaching the relationship between health and society based on the social processes characteristic of its history. Latin American thought style differs in its reasoning about social medicine currently circulating in global health debates. This difference matters because, although the object of study may be similar (health and disease), the incommensurable elements of the region's historical trajectory yield a distinctive epistemology with its own set of rationale, practices and principles. The goal of this thesis is to critically analyse these core elements, to provide a fresh perspective on the social medicine situated specifically in Latin America, and to unveil the tensions and challenges of the thought style.

ALAMES provides valuable contributions that enrich global health debates on topics such as capitalism, healthcare systems, health inequalities, social justice, participatory democracy, engagement with local grass-root movements, interculturality in health sciences, and the history of social medicine in the region. Distinctively, the organization offers views on these issues that confronts the dominant discourses developed by reputable centres in Europe and North America. The goal was not merely to analyse the tensions, ruptures, strengths and shortcomings of the thought style but also to chart how the rationale and practices of social medicine have progressively assembled over time as a result of the twentieth-century Latin American context. This research traces the region's collective narratives and imagined perspectives. The different conditions that made the continent's contemporary social medicine possible in its actual form are shown through the lenses of subjects who represent the emancipatory goals of the collective health movement.

To fully grasp the context as integral to local knowledge and situated epistemologies, this chapter delves into the contextualisation of health in Latin American social medicine by developing two segments. First, the preliminary foundational elements of ALAMES are explored, in preparation for the critical analysis that this thesis develops in subsequent chapters. ALAMES will be presented as an intellectual movement with its own structure and hierarchy, historically-grounded in the life trajectory of Dr. Juan Cesar García, the region's social medicine pioneer. Through the ALAMES narrative on Garcia, the segment also explores the political position of social medicine in twentieth-century Latin America, and its link with the sanitary movements of nineteenth-century Europe. Second, a brief exploration of the history of social medicine from Europe and US is provided from the lenses of authors like Michel Foucault and George Rosen. This will expand on the roots of social medicine as practices of state and urban medicine during the industrial revolution. The shifts in paradigms emerging from the German medical reform found in scholars like Rudolph Virchow and Solomon Neumann are then unveiled, with 'the social' viewed not merely as a matter of environmental causation, but also as social forces pertaining to political, economic, and cultural dynamics. Finally, I explore the most recent movements of social hygienism through the discourses of behavioural sciences and the social sciences of health, linking to the development of Latin American social medicine until the establishment of ALAMES in 1984 for a full closure of the narrative.

II. LATIN AMERICAN SOCIAL MEDICINE ASSOCIATION:

a) ALAMES AS AN INTELLECTUAL MOVEMENT:

The *Asociación Latinoamericana de Medicina Social y Salud Colectiva* or ALAMES is an intellectual movement structured as a transnational non-governmental organisation that brings together regional academics, activists, political leaders and health-related social movements from a wealth of professional backgrounds (ALAMES, 2012). The organisation was established in 1984 at the third Latin American Social Medicine Conference at Ouro Preto, Brazil. The collective is affiliated to the International Association of Health Policy (IAHP), and the People's Health Movement (PHM), sharing public discussions and academic events. While ALAMES shares history and intellectual foundation with Brazil's collective health movement, the Associação Brasileira de Saúde Coletiva (ABRASCO or Collective Health Brazilian Association); the collectives differ in structure, content and organisation. For the sake of simplicity, nevertheless, the terms 'social medicine' and 'collective health' are used indistinctively throughout the thesis to refer to ALAMES.

CLÁSICOS EN MEDICINA SOCIAL

Acta de Ouro Preto. Constitución de la Asociación Latinoamericana de Medicina Social

Los abajo firmantes, asistentes al II Seminario Latinoamericano de Medicina Social, hemos acordado constituir la Asociación Latinoamericana de Medicina Social.

Antecedentes

El desarrollo logrado en la última década por las ciencias sociales aplicadas a la salud. El surgimiento y consolidación de diferentes prácticas en medicina de la comunidad, salud colectiva, salud de los trabajadores y educación para la salud. El nacimiento y desarrollo de algunos posgrados en salud colectiva y medicina social. La presencia cada vez mayor de esta corriente en la investigación, la docencia, la administración y la programación en salud en el continente y la trayectoria de un grupo cada vez mayor de compañeros y compañeras de todos los países de la región en las diferentes vertientes y frentes de trabajo de nuestra corriente en íntima relación con el Grupo Internacional para el Estudios de la Economía Política de la Salud, constituyen los principales antecedentes con los cuales hoy se hace posible y decidimos conformar esta Asociación Latinoamericana de Medicina Social.

Objetivos

Orientados en su conjunto a cohesionar y potenciar la corriente de la medicina-social en el continente y a proyectar en mejor forma se presencia en la problemática sanitaria por las vías de la investigación, la docencia, los servicios, el trabajo directo con grupos de población y la acción solidaria, nos proponemos desarrollar claros objetivos a corto, mediano y larga plazo, cuya formulación encomendamos al Comité Coordinador –CC– cuya conformación definimos en la fecha.

ALAMES

Reglamento

El cumplimiento de los objetivos de nuestra Asociación y el establecimiento de unas mínimas y claras normas organizativas y operativas nos exigen acogernos a un reglamento común. En el marco de una democracia real, de una mínima formalidad, de una óptima operatividad y funcionalidad y de la asimilación positiva del pasado, asignamos también al CC la redacción final del reglamento que nos permita, además, obtener la necesaria legalidad e institucionalidad. Acogiendo en términos generales la propuesta de organización y trabajo presentada por el actual Coordinador del Grupo, recomendamos al CC integrar a los objetivos y reglamentos de nuestra Asociación los contenidos y lineamientos básicos de tal documento.

Sede

Sujeto a los cambios que las reuniones periódicas de la Asociación puedan determinar, escogemos en la fecha a Brasil como país sede oficial de la Asociación. Credenciamos, en consecuencia, a la Asociación Brasilera de Posgrado en Salud Colectiva –ABRASCO– para nombrar en el menor tiempo posible el Secretario Ejecutivo de nuestra Asociación y para realizar los trámites requeridos para legalizar la Asociación.

Igualmente, encomendamos al coordinador que nombramos en la fecha, adelantar los contactos necesarios para incorporar en nuestra Asociación a las personas e instituciones que en toda América Latina trabajan en el campo médico-social y establecer las mejores relaciones con instituciones y personas de interés para el cumplimiento de los objetivos y tareas de nuestra Asociación, en especial con el Grupo Internacional para el Estudio de la Economía Política y Salud, cuya regional en América Latina continuaremos siendo.

Reuniones periódicas

Asumimos la responsabilidad de continuar celebrando cada dos años el Seminario Latinoamericano de Medicina Social, el cual servirá también como periódica de nuestra Asociación. Igualmente, nos comprometemos a organizar y celebrar el próximo Seminario a nivel mundial.

Nombramientos y consideraciones finales

Al hacer finalmente una especial mención del profesor Juan César García, fallecido este año, resaltamos y reconocemos su trabajo pionero de la corriente médico-social en América Latina, su sólido aporte teórico a esta corriente y su liderazgo en nuestra Asociación. Como homenaje al profesor García decidimos instaurar el Seminario Permanentemente "Juan César García", desarrollando eventos nacionales y regionales, estimulando la investigación y denominando a la conferencia central de cada uno de las Seminarios Latinoamericanos futuros "Conferencia Juan César García" cuya amplia divulgación habrá de perpetuar y actualizar su presencia.

Designamos como miembros del Primer Comité Coordinador a los Compañeros:

Saúl Franco Agudelo, Coordinador General
Asa Cristina Laurell y Fabio Salamanca, para México, Centroamérica y el Caribe
Hesio Croderio, para Brasil, Chile, Uruguay y Paraguay
Jaime Breilh, para Bolivia, Ecuador, Perú y Venezuela
Susana Belmartino, para Argentina

Ouro Preto, Brasil, 22 de noviembre de 1984

Asa Cristina Laurell, México
Saúl Franco Agudelo, Colombia
Hesio Cordeiro, Brasil
Jaime Breilh, Ecuador
Sergio Arouca, Brasil
Susana Belmartino, Argentina
Mario Agandoña, Bolivia
Guillermo González G., Nicaragua
Mario Testa, Argentina
Francisco Campos, Brasil
Paulo Marchori Buss, Brasil
David Capistrano Filho, Brasil
Horacio Barri, Argentina
Everardo Duarte Nunes, Brasil
Juan S. Yazlle Rocha, Brasil
César Ganado C., Colombia
Benedictus Philade de Siqueira, Brasil
Ana María Testa Tambellini, Brasil
Francisco de Asís Machado, Brasil
Carmen Fontes Texeira, Brasil

Image 1.1 Acta de Ouro Preto, through which ALAMES was established in 1984 (ALAMES, 2009). Signed by ALAMES pioneers such as Asa Cristina Laurell, Jaime Breilh, Everardo Duarte-Nunes, Mario Testa, amongst others.

The ALAMES collective changes its official address to where the General Secretary is based. At the 2018 ALAMES General Assembly, it was decided to appoint four representatives from across the region by democratic elections for the next period of work. These coordinators represent ALAMES across the continent, assigning one executive member as General Secretary to act as the organisation's point of reference. According to its statutes, the objectives of ALAMES include the expansion of the social medicine thought style, the struggle against the commodification of healthcare services, the critical analysis of contemporary capitalism and neoliberal policies in health, the articulation with other scholars and collectives who participate in the emancipatory activities, the promotion of the collective's academic outputs, the consolidation of social movements struggling for the Right to Health, and the strengthening of foundational principles of social justice in health, including solidarity, dignity, sovereignty, and self-determination (ALAMES, 2012).

The social medicine collective is organised into three different levels. At the top level, the ALAMES General Coordination is in charge of the development and strengthening of social medicine by managing resources, coordinating international events, and releasing official statements pertaining to the affairs of the association and relevant situational concerns. At its second level, ALAMES has an Advisory Committee composed of members with distinguished trajectories within Latin American social medicine, including founders or pioneers, former general coordinators and members with academic and political recognition. The Advisory Committee intercedes in the affairs of the association whenever requested by the General Coordinators or National Chapters.

At the final level, ALAMES organises its members in two ways. On one side, the National Chapters aggregate representatives by territory, bringing together people who take part in local social movements, and/or work at local universities and research centres. The Chapters act in relative autonomy, according to the needs and concerns of their immediate context. They arrange local seminars, conferences, courses, and mobilisations. Currently, ALAMES registers over twelve Chapters including Mexico, El Salvador, Colombia, Ecuador, Brazil, Argentina, Paraguay, amongst others. On another side, the collective is also organised by Research Nodes, where national representatives are affiliated to a particular area of concern according to their expertise. Current research nodes in ALAMES include Occupational Health, Health Policy and Government, Human Right to Health and Healthcare System reforms, Gender and Health, Interculturality in Health, Health Technology and Pharmaceuticals, and the recently established RED-LOMSODES (Latin American Network of Social Movements for the Human Right to Health). The resolutions and statements established within the node may apply to any country in Latin America, and have a broader impact on ALAMES than the National Chapters. However, neither chapters nor nodes dictate the broader course of the social medicine association.

Every two to three years, the transnational association holds its International Conference, which is organised by a National Chapter with the support of the General Coordination, but distributed in themes according to the Research Nodes. The conference is open to anyone, whether members of the association or not. At the end of the ALAMES conference, members of the association gather at the General Assembly where major decisions are made democratically, including the appointment of a new General Coordination, the election of the National Chapter in charge of organising the next

International Conference, and the association's restructuring or reorganizations. Though the dynamics of the collective reveal tensions between the National Chapters and the Research Nodes, the recent COVID19 turmoil in Latin America has brought the collective together around a particular narrative that interprets the context, organises the situational experiences, and offers political action grounded in popular participation. The narrative is feisty and energetic, with a clear anti-capitalist, anti-American, and anti-imperialist way of thinking that also resists the biomedical exclusivism of contemporary institutions. Interestingly, most of the voices contributing to the ALAMES debates are increasingly amassing on social media, transforming the group's militancy into a different type of political action online. The content on these platforms replicates left-wing political perspectives, journal entries, and expert columns of both national and international dissidence, together with the claims and vindications of marginalised and subjugated groups.

Latin American social medicine seeks the re-contextualisation of health and disease processes to accurately capture the complexities of regional societies and their relationship with population health. ALAMES firmly believes that the demystification of power asymmetries, social injustices and epistemological ruptures emerge from the claims and vindications of social movements, grassroots initiatives and popular protests that capture the ground-level struggles across the continent. ALAMES members claim that social movements are the social basis of the collective. As such, the collective health movement acts as the intellectual branch of bottom-up approaches, embodying the values, principles and objectives of social groups that aim for emancipatory and revolutionary horizons in Latin America. The search for profound social processes associated with health and disease in ALAMES – stemming from the structural organisation of society developed throughout the history of Latin America – originates from the efforts of Latin American social medicine pioneers in the 1960s and 1970s. The efforts materialised through the so-called *Latin American social medicine network*, a precursor of ALAMES which mainly followed the professional trajectory of Juan César García (1932-1984), the Argentinian paediatrician, sociologist and public health scholar who was a pivotal figure in the situated thought style. To introduce his significance to the social medicine network, a brief exploration of twentieth-century health epistemology is necessary, beginning with US philanthrocapitalism, and the introduction of preventive medicine to Latin American medical schools.

b) PREVENTIVE MEDICINE IN THE ERA OF JUAN CESAR GARCÍA:

During the first half of the twentieth century, various philanthropic branches of large corporations, such as the Rockefeller Foundation and Carnegie Foundation, funded the establishment of Public Health and Preventive Medicine Departments across the US (Silva Paim and Almeida-Filho, 1998, 2001). The thrust of the initiative acquired international proportions with the 1952 Conference on Preventive Medicine Education at Colorado Springs, constituting the starting point for the most extensive medical curriculum reform in North America. The reform fully incorporated public health into medicine, prompted the expansion of Preventive Medicine departments, and strengthened the dominance of a pre-clinical way of thinking in health epistemology. The enthusiasm of these changes in the US influenced international organisations that followed the Colorado Springs meeting, including the Pan American Health Organization (PAHO). To apply preventive medicine across Latin America, PAHO sponsored the Seminars on Medical Education at Viña del Mar, Chile (1955) and Tehuacan, Mexico (1956) (see also Duarte-Nunes, 1991)[1].

During the 1950s, PAHO cooperated with international health foundations to systematise regional seminars and academic events that structurally changed the medical curriculum to align with North American preventive medicine standards. Both the Rockefeller and Milbank Foundations, as well as the Point Four Programme, joined efforts to establish the changes, distributing different roles in the endeavour (García, 2007:154). National seminars and events, sponsored locally by developmental policies, were carried out in countries such as Brazil (1964), Venezuela (1967), Colombia (1969), Ecuador (1971), and Peru (1974); alongside many journal publications, books, debates and resources advocating preventivism (Arouca, 1975a; Duarte-Nunes, 1991). The preventive medicine reform became a movement financed by international organisations, and quickly spread across Latin America's leading medical schools. Shortly after its enormous success, PAHO organised the first evaluation of the preventive medicine strategy, financed by the Milbank Foundation. The project included collaborative efforts with Harvard University in the late 1960s, when Juan César García was working as a research assistant there (Duarte-Nunes, 1991; Galeano et al., 2011; Duarte-Nunes,

[1]Alongside Colorado Springs, authors argued that the rapid expansion of preventivism in Latin America was also due to other conferences in the Global North (Duarte-Nunes, 1991; Mota et al., 2017; Arouca, 1975a:91-92). These included the WHO-sponsored meetings on Preventive Medicine held at Nancy in France (1952), Gothenburg in Sweden (1953), the First World Conference in Medical Education held in London (1953), the First Pan-American Congress on Medical Education in Peru (1951), the First Seminar in Medical Education at Cali in Colombia, and many others.

2015; Rovere, 2016). García was commissioned to evaluate the progress of preventive medicine in Latin American universities, the results of which he presented in his most iconic publication: *La Educacion Medica en America Latina* (Medical Education in Latin America, 1972). The document corroborated the resounding success of efforts by the international health organisations in implementing the preventivist approach across the region's medical programmes.

Juan César García was born to a humble household in a small town outside Buenos Aires, Argentina in 1932. His family was strongly influenced by socialist and communist ideology. His mother's relatives were Basque immigrants who settled in Argentina in the late nineteenth-century, searching for better living conditions. Various close relatives joined the regional communist party, and held positions of political relevance as newspaper directors and bureaucratic leaders, exerting considerable revolutionary influence on García. His own political activism began at the Universidad de la Plata medical school in the early 1950s, coinciding with the first populist government of Juan Domingo Perón (1946-1952), founder of the Perónismo movement that aggregated social movements, syndicates and feminist political parties against Argentina's military dictatorships of the 1940s. Despite strong support for the lower class, Perón's government promoted regressive university measures, including the suspension of institutional autonomy, the derogation of democratic management, and abusive regulation through purges and overhauls. García consequently opposed Perón's policies, and took part in anti-government student unions, leading the young medic to prominent leadership positions that opened him up to the realities of other marginalised populations. García's insertion into student politics significantly shaped his political ideas, while bringing him closer to local struggles and resistance against Argentina's elite class (Galeano et al., 2011).

Image 1.2 Juan Cesar Garcia (first on the left) and colleagues touring Argentina in the late 1950s. Source: Galeano et al., 2011:290.

After medical school, García pursued a paediatric residence in community medical practices close to rural La Plata, a city with many social challenges. According to Duarte-Nunes (2013), the experience led García and his colleagues to travel around the country in order to undertake health research on living conditions in peripheral towns and cities (a neglected topic in Argentinian political affairs). The study into the social processes of health, alongside García's ideological position, led him to shift from the medical sciences to the social sciences, undertaking a sociology postgraduate degree at the *Facultad Latinoamericana de Ciencias Sociales* (FLACSO, Latin American Faculty of Social Sciences) - a UNESCO postgraduate institution, committed to the professional development of Latin American scholars.

In 1955, a military coup labelled the *Revolución Libertadora* (Liberating Revolution) overturned the second Perón government that had been re-elected in the early '50. The coup caused hundreds of casualties, and inaugurated a new period of violence in the country. Though it enacted important

constitutional changes to progressive policies from the Peron's government (trumping, for instance, rights such as judicial equality of gender in marriage), the coup also promoted developmental policies that favoured international cooperation. The policies included scholarships to the Chilean branch of FLACSO, from which García benefited (Galeano et al., 2011). The goal of the Argentinian regime was to build up a 'mass' of critical social scientists to support and strengthen the socioeconomic goals of its emerging capitalist policies. Education at FLACSO had been predominately based on North American positivism and functionalism in health, along the lines of Talcott Parsons's structural thinking, and Leavell and Clark's natural history of disease model (García, 1971a, b, 2010; Duarte-Nunes, 2015). The institution, therefore, was quite instrumental for the purposes of the Argentinian regime. FLACSO's ideological milieu, nevertheless, introduced García to the application of Marxist historical materialism in health that would be pivotal for the constitution of Latin American social medicine network in subsequent decades (Marquez, 2015).

Through FLACSO's international opportunities, García was recruited by Harvard University in 1964 to continue his research career, where he eventually joined the PAHO in 1966. With this new institutional involvement, García was commissioned to lead a working group to study the state of Latin America's medical education. In 1967, García began to travel to universities all over the continent, assessing the development and application of preventive medicine that had begun with Seminars in Medical Education in the 1950s as described above (García, 1969). With the support of various national medical faculties associations, García connected with deans, professors, staff and students to apply research methods, and collect data. The endeavour was nevertheless used as a stepping stone to begin recruiting and consolidating what eventually came to be known as a *Latin American social medicine network,* an aggregation of academics and activists committed to a different type of social sciences in health. The network gathered critical figures in Latin American social medicine, including Sergio Arouca, Hesio Cordeiro, Susana Belmartino, Cecilia Donnangelo, Miguel Marquez, Maria Isabel Rodriguez, Jose Teruel, Jaime Breilh, Saul Franco, Mario Testa, Hugo Mercer and Asa Cristina Laurell, amongst many others. The network distinctively took a highly critical approach from Marxist historical materialism, questioning the epistemological basis of preventive medicine, and firmly articulating with the social struggles and popular movements in the region. It served as the platform for the intellectual movement throughout the 1970s, and represented preliminary efforts towards the founding of ALAMES.

By gathering data, García was able to expand the social medicine network across the continent, aggregating research centres, accumulating social capital, and establishing lines of communication at a time of limited freedom. Distinctive of the Latin American context, scholarly work in the 1970s was carried out in secrecy to protect the safety of members, and the continuity of the network. Miguel Marquez, ALAMES founder and honorary professor of Public Health at the Universidad de Cuenca (Ecuador), stated: "García completed a journey very similar to "Che" Guevara's, interviewing, witnessing and listening. Not just appreciating the development of preventive medicine in Latin America, but understanding the dilemmas and ruptures that differentiated social medicine in the region" (2015). Engaging with other academics enabled García to contemplate the multiple critiques against the health epistemology in the region, and also to understand the relevance of situated experiences and local context in the development of social medicine.

Although already a Marxist, García's publications during his time at Harvard were still functionalist, in line with the preventive medicine approach. When encountering challenges to the dominant health epistemology by authors such as Sergio Arouca (1975a), Anamaria Tambellini (1975, 1978) and Cecilia Donnangelo (1975, 1979), García revised his academic approach to include social medicine scholars like Rudolph Virchow, Henry Sigerist and Erwin Ackerknecht. García remained at PAHO until his death in 1984 where, through his extensive work at the Human Resources Department, he achieved remarkable accomplishments. These included the promotion of social medicine research centres across the region, the constitution of several social medicine postgraduate degrees, and the growth and consolidation of the social medicine network (Rovere, 2016). His institutional trajectory is further explored below.

Juan César García became head of the Human Resources Department at PAHO in the early '70s, where he managed multiple funding efforts to set up social medicine programmes across Latin America. PAHO faced significant changes in leadership and ideology that hampered the progression of the Latin American network, forcing García's department to work in secrecy (Galeano et al., 2011). To ALAMES members today, Garcia acted as a 'mole' within PAHO, sponsoring a way of thinking contrary to the dominant position of the international health organisation (Rovere, 2018b). According to Rovere, PAHO representatives like Juan Cesar García, Miguel Marquez, Maria Isabel Rodriguez, Jose Teruel and Carlos Vidal were the '*mecenas de la izquierda'* (patrons or protectors of leftist politics) - key actors that consolidated social medicine in the region. Being an intellectual

movement, the Latin American social medicine network and ALAMES were established primarily through academic degrees. Two in particular are foundational: the Masters in Social Medicine at the Institute of Social Medicine, established in 1973 at the *Universidade do Estado do Rio de Janeiro* (UERJ, Brazil); and the Masters in Social Medicine at *Universidad Autonoma de Mexico-Xochimilco* (UAM-X, Mexico) in 1975.

Duarte-Nunes explained that the Institute of Social Medicine at UERJ was the result of a project in social sciences in health at the postgraduate level in Latin America, elaborated by the United Nations Developmental Program, and established through the efforts of PAHO and the Kellogg Foundation (1991:48). The course initially aimed to support the spread and consolidation of behavioural sciences at the heart of renewed preventive medicine in the early 1970s, later redefining its ethos towards critical approaches. It partnered with the Centro Brasileiro de Estudos de Saúde (CEBES or Brazilian Centre for Health Studies) at the Fundação Oswaldo Cruz/Fiocruz, and received ample involvement from the Brazilian reformist leader Sergio Arouca (see also Cordeiro, 2004). The project was managed and directed by García, in collaboration with like-minded scholars he had met during his fieldwork for the 1972 book on medical education. Scholars included Hesio Cordeiro, Jose Pelucio Ferreira and Mario Chávez – all highly influential leaders in Latin American social medicine. Through the involvement in the programme of these critical academics, alongside the close links with the prolific emancipatory movements in Brazil at the time, the Master's in Social Medicine had a curriculum that provided alternative approaches to preventive medicine, and focused on unveiling the consequences of growing capitalism in the provision of healthcare.

In the 1970s, Garcia's Human Resources Department also commissioned a team to work in Mexico due to the country's rich academic environment. The intellectual milieu was particularly welcoming to exiled scholars from countries with military dictatorships that persecuted and repressed socialist/communist leaders. Maria Isabel Rodriguez was appointed by García as PAHO's representative in Mexico, where she organised events to sponsor and support social medicine. During the first Seminar of Social Sciences and Health in 1974 at Universidad de Guadalajara, she partnered with Dr Ramon Villareal, the former director of the Medical Education Department at PAHO, who at the time was Chancellor of UAM-X (Rodriguez, 2019). The following year, the partnership resulted in the founding of the Social Medicine Department at UAM-X, bringing together social medicine academics such as Hugo Mercer, José Carlos Escudero, Catalina Eibenschutz, and

Asa Cristina Laurell. Both programmes at UERJ and UAM-X were training schools for prominent ALAMES leaders who today are at the association's forefront. They include Jaime Breilh, Saul Franco, Oscar Feo, Rafael Gonzales, Olivia Lopez-Orellana, and Sara Fernandez. A few additional research centres worth mentioning in Latin America's social medicine network include the Centro de Estudio Sanitarios y Sociales (CESS or Centre for Sanitary and Social Studies) at the Universidad del Rosario in Argentina, Centro de Estudios del Desarrollo (CENDES or Centre for Developmental Studies) at the Universidad Central de Venezuela, the Centro Venezolano de Estudios en Salud (Venezuelan Health Research Centre) in Carabobo University, Centro de Estudios y Asesoria en Salud (CEAS or Center for Health Studies and Advice) in Ecuador, and the Universidad Nacional de Lanus in Argentina, to name but a few.

Apart from the institutions above, the gatherings and development of the *Latin American social medicine network* was also pivotal for the establishment of ALAMES in the '80s. Following his significant recruitment journey across the continent, García organised the first Latin American Social Medicine Seminar in 1972 at the Universidad de Cuenca in Ecuador – home of PAHO colleague and close friend Miguel Marquez, who was Dean of the medical school in the late 1960s and had remained closely associated with the university. The seminar, later renamed 'the Cuenca I Meeting,' was significant as it brought together for the first time the newly-emerging social medicine network to a major event.

'Cuenca I' reached agreements on common themes and objectives that were foundational to social medicine in the region, including the critical position against the functionalist, positivist and behaviouralist theoretical framework of dominant preventive medicine; the collective's commitment to historical materialism as its epistemological basis, and the resistance to the reductionist approaches of biomedicine. Throughout the rest of the 1970s, multiple national meetings were organised across the region, consolidating the network, and spreading ideas against the natural history of the disease model, the linear causation of the risk factor paradigm, and the 'static conception' of the health and disease process of institutionalised public health (Galeano et al., 2011; Duarte-Nunes, 1986). During the early 1980s, a consolidated group of social medicine scholars began meeting more frequently, in the lead up to the Ouro Preto agreement: the first Latin American Social Medicine Conference was organised by the UAM-X team in 1982, directed by Asa Cristina Laurell; and an additional Latin American Social Medicine Workshop was held in Managua,

Nicaragua the following year, in the midst of the Sandinista revolution, and sponsored by the state-funded Universidad Nacional Autonoma de Nicaragua.

The resounding success of the meetings prompted García and Marquez to organise the second Latin American Social Medicine Seminar in 1983, again at Cuenca Ecuador, otherwise known as 'the Cuenca II Meeting'. The event brought together a larger and more critical cohort of academics from the various research centres, and postgraduate programmes mentioned above. The seminar yielded the publication *Ciencias Sociales en Salud en America Latina: Tendencias y perspectivas* (Social Sciences and Health in Latin America: Trends and Perspectives), published in Spanish and Portuguese by Duarte-Nunes (1986). Cuenca II clarified the epistemological horizon of the social medicine thought style by ratifying its footing on critical theory, and integrating qualitative methods found in disciplines like anthropology and sociology.

Image 1.3 Conference talk at the Cuenca II meeting in 1983 (Ecuador). Juan Cesar Garcia is third from the left to the right, on the first row. Source: Waitzkin et al., 2001:1595.

By the time of the Cuenca II meeting, García was battling advanced-stage Hodgkin's Lymphoma, which would eventually take his life in 1984. Several conference attendees, scholars heavily influenced by García and members of the Latin America social medicine network, came together at Ouro Preto Brazil in the year of his death for the third Latin American Social Medicine Seminar. Their goal was to achieve García's highest aspiration: the formation of the first transnational social medicine association in Latin America that would embody the principles and political goals of the social medicine network. Then and there, ALAMES was born. The founding scholars of the association included Saul Franco, Hesio Corderio, Maria del Carmen Troncoso, Sergio Arouca, Susana Belmartino, Sonia Fleury, Edmundo Granda, Carmen Fontes Texeira and Maria Isabel Rodriguez. On November 23rd, 1984 ALAMES was established, honouring García's contributions by naming the central lecture of ALAMES International Conferences, the *Conferencia Juan Cesar García*, a tribute which has continued for the past 35-plus years of the association.

c) THE OPPOSITIONAL POLITICS OF SOCIAL MEDICINE:

Latin American social medicine is an example of a non-dominant health epistemology whose particularity derives from the standpoint of the subjugated groups it represents, which crafts a type of oppositional politics with radical goals in the collective. Consequently, the ALAMES collective presents its thought style as intimately grounded in the claims and vindications of popular protests, social movements and mass strikes characteristic of Latin America in the twentieth-century. The collective health movement joined social struggles that reacted and resisted multiple military dictatorships, political persecution, ideological stigmatisation, repression, kidnapping and murder of left-wing social leaders that marked the trajectory of the region at the time. The central theme linking the chapters together, therefore, is the underlying collective social medicine discourse frequently portrayed in 'subversive,' 'revolutionary' and 'emancipatory' terms. This theme is developed throughout the thesis by way of two predominant features derived from the biographical accounts of ALAMES members: (i) the situated diagnosis of twentieth-century Latin America, and (ii) the analysis of epistemic injustices in the region.

On the former feature, given the predominance of Marx's historical materialism and critical theory in the epistemological basis of ALAMES, Latin American social medicine is deeply rooted in an anti-capitalist, anti-imperialist and anti-colonial perspective. The collective health movement is

characterised by the construction of a critique of the current market economy in Latin America, and by applying structuralist social theory to health issues. The thesis, therefore, explores the social medicine use of 'capitalism' as the key driver of the thought style by transforming the meaning of the term during its trajectory. The shifting nature of capitalism as a concept in ALAMES can be broken down in stages.

A first stage, explored in chapter three and four, emerges during the foundational years of Latin American social medicine network in the 1970s. 'Capitalism' predominantly referred to the socioeconomic model imported and imposed by the US, in partnership with the elitist state and local oligarchic classes through the developmental policies and reforms. The multiple promises of social progress and financial growth embedded in the discourse of developmentalism in the second half of last century were heavily criticised by the social medicine collective for years. The ALAMES study of local experiences at the time yielded a situated diagnosis revealing the exponential increases in social inequality, material misery, power asymmetries and systematic injustices linked to the emerging capitalist societies and the imperialist tendencies of the international organisations involved. The common critique of the socioeconomic model brought the social medicine members together, crafting a socialist approach to defining health and disease in academia, and politics.

The second stage during the 1980s was characteristic for Latin American social medicine analysis of the impact that capitalism, as a socioeconomic model, had on health epistemology in the region. As explored in chapter four, through the scrutiny of preventive medicine and institutionalised public health taught in medical schools, ALAMES conceived 'capitalism' not merely as a way to organise societies around market principles, but also as a framework to make sense of health and its relationship with society. Also conceptualised as the *Hegemonic Medical Model,* the preventivist paradigm was heavily confronted by the collective health movement, questioning such views as the underlying functionalism in health, the linear causation framework that directs healthcare practices, the reduction of life processes to biological mechanisms, and the positivist fragmentation of social dynamics associated with population health. Rather than dismissing medical evidence-claims and practice, the collective health movement argues against the exclusive status of preventivism for omitting other types of knowledge and disabling alternative perspectives on health that fell outside of its epistemic coordinates. For the ALAMES collective, the privileged status of the capitalist medicine resulted from the market model in health that co-opted the rationale and practices of

clinical medicine, and built on the absolute value of empiricist, positivist and functionalist sciences. Therefore, the opposition to biomedical exclusivism became an extension of ALAMES's anti-capitalist stance that conceptualised 'capitalism' as the dominant way of reasoning the social basis of health and disease.

A last stage emerged with the advent of the neoliberal reforms in the 1980s and '90s across Latin America, which prompted a wave of social mobilisation and popular protests against economic 'orthodoxy' that chapter five and six explore. The social movements opposed the market logic entering social services characteristic of welfare states, including healthcare and education, as well as the massive privatisation of essential resources such as water, electricity and natural gas. Additionally, the free-market policies enabled the exploitation of land and massive environmental damage, which led to strikes responding against the high rates of deforestation, land exhaustion, as well as natural resource extraction of oil and mining. As a result, strong Indigenous and rural movements emerged to present alternative ways of conceiving the management of nature and sponsor different worldviews to replace capitalism. For Indigenous communities, Latin American colonial heritage transcended the shackles of seventeenth and eighteenth-century colonialism to become a modernising project characteristic for its racism and exploitation against local culture. Capitalism for these groups, therefore, represents the root cause of current social asymmetries determining population health and disease, and the evil behind the destruction of nature. Resulting from the impact of Indigenous movements, social medicine integrated their views, transforming its own understanding of advanced capitalism from a socioeconomic model and a way of conceiving the relationship between health and society to a 'civilising project' that structurally determines the ethos of contemporary societies.

On the latter feature that embodies the 'subversive' theme of ALAMES, the collective imagines the rationale and practices of social medicine as spearing the ongoing struggle against 'epistemic injustice' in the context of Latin American liberal, biomedical and capitalist societies. 'Epistemic injustice' refers to a type of status asymmetry among thought styles, based on arbitrary and socially-constructed standards which marginalise certain viewpoints. These 'rules' or criteria determine the legitimacy and authority of the style of reasoning in absolute terms, dividing the viewpoints in a value hierarchy. At the top, the 'scientific' and objective perspectives are considered adequate, accurate and/or superior. At the bottom, other more 'subjective' views are deemed inadequate,

inaccurate and/or inferior. And outside of all consideration rests situated or local knowledge from cultural subgroups, which are rendered invisible, unworthy and irrelevant. Epistemic injustice is pivotal for the social medicine thought style, as the collective has suffered from the status asymmetry, have reproduced injustices onto other epistemologies, and continues to wrestle with the topic to this day. The analysis of the biographical experiences of ALAMES members *vis-à-vis* the contextual trajectory of Latin American history unveils the progression of epistemic injustices in the region, in parallel stages to the progression of capitalism as explained above.

Firstly, the foundational years of Latin American social medicine clashed with the *Hegemonic Medical Model* during the establishment and consolidation of developmental policies in the region, as explored in chapter three and four. As background, it is important to note that Post-Second World War Latin American politics broadly followed the US McCarthyism approach, ostracising and vilifying any ideology that came close to socialism and communism. The anti-communist posture justified the existence of illegal paramilitary groups and institutional violence against left-wing political leaders and academics, resulting in what ALAMES called the 'holocaust of the political left' characteristic for the persecution, kidnap and slaughter of members (Granda, 2009a:44). The tragedy resulting from fascist regimes heightened with the triumph of the Cuban Revolution, and the multiple revolutionary movements that followed in virtually every Latin American country. The socio-political upheaval prompted the US government to back several bloodthirsty military coups in countries like Chile, Bolivia, Brazil and Argentina; and eventually support state violence through the so-called *Plan Condor*.

Parallel to these events, the collective health movement advanced alternative frameworks in health epistemology that were particularly critical of North American imperialism, linking with the claims and vindications of local social struggles on the stigmatisation, repression, persecution and murder of social leaders. ALAMES biographical accounts and life-course narratives highlight the marginalisation of their critical approaches in social medicine perpetrated by the traditional public health dominant in medical schools and health science departments across the continent, due to the collective's close association with Marx's critical theory. Latin American social medicine, in this way, devised its situated epistemology as part of the region's subjugated struggles, crafting a form of counter-hegemonic knowledge through the militancy of its members.

Secondly, the relevance of Indigenous movements in the region during the 1990s challenged the progress of the ALAMES thought style as it inadvertently reproduced the same epistemic injustices social medicine had been a victim of during the twentieth-century. Derived from the Indigenous worldview also known as *Buen Vivir* (or Living Well), the Aboriginal communities laid bare the asymmetries between modern scientific reasoning and local ways of reasoning resulting from the colonial-inspired stigmatisation of Latin American ethnic epistemologies. During the *Buen Vivir* dialogue with social medicine, explored in chapter five of the thesis, the Indigenous groups made evident the dependence of ALAMES epistemological framework on many foundational elements of western modernity. According to the Indigenous collectives, the epistemological proximity with western modernity explained the continuous tendency ALAMES had to maintain the asymmetries imposed by biomedical approaches. The shift within ALAMES to incorporate the Indigenous movements resulted in a significant destabilisation of its epistemological foundations in ways this document will reveal throughout chapter five.

Lastly, in more recent decades, ALAMES suggests other forms of epistemic injustices occurring within health epistemologies in the region, due to the dominance of the so-called *managed competition* or *structural pluralism* in the healthcare systems and reforms debates. As will be explored in chapter six, *managed competition* corresponds to the commodification of health services from neoliberal reforms in the late twentieth-century. The model consolidated the narrowing of health epistemology into the biomedical paradigm, the rationalisation of medical resources, and the managerial response to health problems. Also termed 'pharmaceuticalization of public health', the ALAMES collective experienced a new wave of marginalisation as a result of the dominant definition of health and disease as purely concerns dealt through health technologies, healthcare services and laboratory devices. Its own critical social science perspective, therefore, has been predominately viewed as irrelevant and burdensome. In this way, the struggle for health epistemology by social medicine today consists of the diversification of medical thinking by integrating local knowledge that bring about different evidence from a wealth of other worldviews and perspectives.

It is noteworthy to understand that the inclination to present social medicine in emancipatory and revolutionary terms is grounded in a specific understanding of the history of social transformations, and the way the collective health movement fits with them. For different ALAMES members, Latin

American social medicine nurtured its oppositional politics from two sources of critical thinking on the history of ideas: on one hand, the revolutionary ideas of early social medicine pioneers in Latin America during the so-called 'Golden Age' of social medicine; and the transformative struggles of social hygienist movements of nineteenth-century industrial Europe, on the other.

The 'Golden Age' of Latin American social medicine: The ALAMES collective built an image of revolution and transformation by referencing older icons of Latin American social medicine as predecessors of the collective health movement. The organization distinctively points to the bundle of physicians and political activists of the first half of twentieth-century, otherwise known as 'The Golden Age' of the region's social medicine, to construct its militant persona (Waitzkin et al., 2001; Gonzales, 2018b). The way social medicine conceptualised the context of the early twentieth-century is pivotal in order to understand how ALAMES imagines itself as the continuation of revolutionary movements in the region. According to Breilh (2018a), the awareness, establishment and consolidation of critical ideas in health sciences always occurred during revolutionary periods in western history, marked by the upheaval of social mobilisation and the uncertainty of political turmoil. By leaning on the uprisings of the past in Latin America, Breilh suggests that the collective health movement acquired value as an emancipatory and group from belonging to the longer transformative trajectory of the situated history of social medicine.

According to Gonzales (2018b), lecturer on public health at UAM-X and former ALAMES coordinator, the 'Golden Age' of Latin American social medicine was distinguished because it originated in the social movements and popular protests that arose in the region, struggling against the worsening of living and working conditions during the early twentieth-century. The political climate at the time was distinctively nationalist, anti-imperialist and class-oriented. It represented early Latin American efforts to embody Marxist orthodoxy through local class struggles against the system of economic dependency sponsored by the ruling class. In so doing, social medicine crafted a vision that was deeply rooted in a sense of self-determination by the collectives, the radical democratisation of societies, and the equal social standing of individuals and groups. Gonzales contended that, rather than the bureaucratic top-down approach frequently drowned in corruption and fraud at the time, the social movements opposed the representative democracy model, and instead aimed at forms of direct governance based on local collectives. Gonzales concluded that the political objectives of

Latin American movements and revolutions during the 'Golden Age' resembled the *Mandat Imperatif*, typical of the Paris Commune and Council Communist movements in Europe.

The populist protests of the 'Golden Age' distinctively pioneered both the constitution of bottom-up approaches to resolving the main concerns of immediate social struggles, as well as strengthened the first wave of left-wing Populist governments that swept Latin America in the 1930s and 1940s. According to Gonzales, prior to the left-wing populist politics, early twentieth-century Latin America was marked by the dominance of elitist sectors that had maintained power through electoral fraud and corruption, and precluded the necessary reforms sought by local insurgencies. A prolonged feudal system that reproduced class dependency in the regional economy further aggravated a monopoly over land ownership, the persistence of illiteracy and labour exploitation, and the oppression of peasants and subordinated farmers.

In response, the multiple democratically-elected populist governments established in Latin America gained thrust with the people by relying on a strong sense of national identity, supporting welfarist policies that favoured syndicalism, and opposing foreign involvement in national affairs. The socialist movements materialised in the governments of Juan Domingo Perón in Argentina, Getulio Vargas in Brazil, Jose Maria Velazco in Ecuador, and Lazaro Cardenas in Mexico, amongst others. The public administrations of these leaders enabled the growth and consolidation of social medicine scholars and political activists, including Salvador Allende and Santiago Arcos (Chile), Ricardo Paredes and Pablo Arturo Suarez (Ecuador), Juan B. Justo and Ramon Carrillo (Argentina), and Arnoldo Gabaldon (Venezuela). Despite positive transformations (also supported by multiple international organisations, in Carter, 2019), regional politics from the 1950s onwards shifted towards violent persecution and repression of socialist leaders and activists, representing a real backlash in the advances made on social welfare in prior decades. Military dictatorships emerged, and totalitarian policies were established to impose an extractivist economic model and social control through violent means.

The zenith of the 'Golden Age' transformative potential was reached with the success of the Cuban Revolution in 1960, which prompted a new radical shift in Latin American politics. Cuba demonstrated a truly populist transformation of society by replacing the socioeconomic model and ethos of society using communist ideals and public investment in health and education. Various

popular revolutions followed, representing iconic and exemplary processes in the history of Latin America that shaped the development of the ALAMES social medicine in subsequent decades. These revolutions included the Bolivian national revolution, the Nicaraguan Sandinista Revolution, and the Zapatista Movement in Mexico. The region was also distinctive for the rise of multiple National Liberation Armies including the *Frente Farabundo Marti* FMLN in El Salvador, the *Fuerzas Armadas Revolucionarias de Colombia* (FARC) in Colombia, and the *Sendero Luminoso* (Shining Path) in Peru. "Suddenly," Gonzales observed, "the revolutionary phenomena led many people in the continent to imagine that the end of capitalism was near, that is, the form of hegemony also called *oligarchy* was meeting its demise" (2018b). With this emancipatory impetus, Latin American social medicine visualised its thought style as the academic expression of these movements, embodying the principles, concerns and objectives of the long process of transformation in the region.

Former Chilean president, physician and public health scholar Salvador Allende was a notable example of the extent to which social medicine pioneers from the 'Golden Age' exerted enormous influence on the ALAMES militancy. In an unprecedented manner, Allende constructed explanatory models for the health and disease processes, based on the particular context of underdevelopment in Latin America (Waitzkin et al., 2001:1593). According to Waitzkin, distinguished professor of sociology at the University of New Mexico and honorary member of ALAMES, Allende grounded his medical practices and political activism on the European social hygienic movement. Inspired by the teachings of Max Westenhofer, his pathology professor at the Universidad de Chile and former pupil of renowned scholar Rudolph Virchow, Allende's particular contributions mark him to be an essential reference for the social medicine thought style.

In 1939, Allende published his iconic book *La Realidad Medico-Social Chilena* (The Chilean Medical-Social Reality) while acting as Chile's Health Minister, achieving what no other document had done before in Latin America. The book provided evidence and arguments for the causal links between health phenomena and seemly-unrelated social dynamics that included foreign debt, illegal abortion, and the material conditions of misery. The work demystified the relationship between political economy, disease and suffering, and is an exemplary criticism to rising imperialism, underdevelopment and the need for structural transformations. Allende rightly deviated attention from dominant treaties that attempted to optimise medical approaches and social insurance

schemes. His epistemological contributions distinctively devoted efforts to the social analysis of the Chilean context, to suggest political actions for the management of the population's health.

As noted by Waitzkin, once elected senator in the early 1950s, Allende's political success enabled the most significant contribution in the historical trajectory of healthcare in Latin America – the creation of the first national healthcare system on the continent. Allende "linked this reform to other efforts that aimed to achieve more equitable income distribution, job security, improved housing and nutrition, and a less dominant role for multinational corporations within Chile" (Waitzkin, 2001:1593).

The success of Allende's socialist policies earned him outstanding support from ongoing populist movements that became pivotal for his presidential victory in the 1970 elections. As president, his continuous structural reforms led the country into complex socioeconomic and political crises because of frequent clashes with the elite classes. The social turmoil of the era, mixed with foreign interest to oust all socialist influences in Latin America, resulted in the CIA-supported military coup of Dictator Augusto Pinochet in 1973, which led to Allende's death and the violent persecution of socialist leaders. This phenomenon was later labelled 'The Caravan of Death', one of the deadliest interventions to establish neoliberalism in Latin America. Allende stands as an exemplary case of capitalism domination, US imperialism, and the necessity for counter-hegemony and resistance by social medicine in the region.

ALAMES and European social medicine: Aside from the Latin American 'Golden Age,' Europe's nineteenth-century social medicine movement is an additional source of critical thinking for the social medicine thought style. The collective health movement classed itself as a continuation of the historical efforts against the structural injustices of the European industrial societies. For various ALAMES members, the commonality between the collective health movement and the social medicine reformers of Europe resides on the shared struggle against the worsening living and working conditions of capitalist societies. This motivated ALAMES to conceptualise Latin American social medicine as the situated version of the European movements (Silva Paim, 1998; Granda, 2008; Marquez, 2011a; Laurell, 2011). Based on narratives from the nineteenth-century social medicine disputes, ALAMES members conceived health epistemology as the confrontation between two ways

of understanding health and disease that established a hierarchy of status predominant to this day (Feo, 2018b).

According to Oscar Feo, former ALAMES general coordinator and professor of public health at Universidad de Carabobo in Venezuela, the first way of thinking corresponded to the dominant biological perspective that conceived the relationship between society and health in linear terms (an external agent impacting the body). This 'hegemonic paradigm' interpreted society as a bundle of variables that worked together to exert influences on the body by triggering pathological mechanisms of disease. This framework focused on the biological processes of the environment and the body, rendering the social basis of health and disease a mere interaction with 'risk factors' that could be acted on through health technology and behavioural approaches. Feo suggested that mainstream medical thinking reduced society to a second-order aggregation of variables that were quantifiable and static, obscuring the underlying processes that determine population well-being (including power asymmetries, oppressive relationships, and historically-determined injustices).

By contrast, the second way of thinking health and disease corresponded to the 'medico-social' or critical approach sponsored by the 1848 European social medicine epistemology. Rather than the 'static' and 'inert' notion of health causation from the biological view above, the critical perspective according to Feo argued that conditions associated with health are produced and reproduced from underlying structures which are established in the trajectory of a society. Consequently, European social medicine conceived society as a bundle of processes, dynamics and relationships that developed historically, ultimately determining the standing injustices, asymmetries and conditions that cause the distribution of population health and disease. Its main objective as an emancipatory field of health is to unveil, demystify and tackle the underlying structures in society, grounded in the understanding that health and disease processes are socially determined (and, therefore, liable to change) (see also Gonzales, 2018a).

The confrontation of the two ways of thinking was best illustrated by the clash between Rudolph Virchow and Robert Koch at the Berlin Academy of Sciences, which Feo narrates with great eloquence. According to Feo (2018b), Virchow and Koch met in the late 1880s on opposite sides of a debate relating to Koch's recent discovery of the tuberculosis bacteria. Although Koch was 20 years younger, he challenged Virchow's social medicine approach by relying on the microbiological

paradigm that promised the control of society's most pressing diseases without radical social transformation. Virchow, acting as the president of the Berlin Academy at the time, recognised Koch's findings and arguments, but stood sceptical about its possibilities. Feo explained that the two strands of health epistemology in the debate were at odds about health causation, and their relationship to social processes. While Koch's research demonstrated the essential influence of external and measurable agents in the development of diseases, Virchow defended a holistic comprehension of health and disease processes that were linked to underlying structures of society from which disparities in health develop.

According to Feo, the conflict between views was settled when Koch was awarded the Nobel Prize in Physiology or Medicine in 1905 for the discovery of the *Mycobacterium tuberculosis* - setting the stage for the omission of critical 'medico-social' approaches on health for decades to come. Feo observed: "The resolution of the tension came with the Nobel Prize to Koch, which served as the sign of the pre-eminence of the biological and mechanised thinking over and above the historical and social perspective" (2018b). For Feo, the events surrounding the award gave way to the asymmetry of status between social medicine and the biomedical paradigm, determining the trajectory of critical approaches in liberal western societies as collateral and secondary to the dominance of the reductionist sciences.

ALAMES members also drew on a similar confrontation and outcome in England's mid-nineteenth century when debates about public health took place between William Farr, who represented a 'medico-social' approach, and Edwin Chadwick, who defended the natural causes of disease (Gonzales, 2018b). The debate, which determined the course of the New Poor Law in England, ultimately favoured Chadwick's stance, arguing that disparities in the distribution of disease originated from diseases like diarrhoea and tuberculosis rather than stemming from starvation and poverty associated with emerging industries. Chadwick advocated for an emphasis on infectious agents that could be tackled through medical interventions, supporting the dominant utilitarian approach that focused on healthcare services, and pharmaceutical development. Years later, Gonzales concluded, the New Poor Law prompted the antecedent conditions of what would become the market in healthcare, and enabled the worsening of living and working conditions for the most vulnerable associated to the industrial revolution. The law weakened efforts to abolish labour

exploitation, poor housing, overpopulation around factories, unsafe drinking water, a lack of sewerage systems, and the growing pauperism.

For the social medicine collective, the monocausal and reductionist view of biological health epistemology has dominated the history of contemporary medical practices. This is evident in the contemporary state of affairs in clinical practices, health institutions, and medical education. In contrast, ALAMES advocates for understanding health and diseases as emerging from social processes in the history of Latin America, which structurally determines the contemporary health disparities in the population. The collective health movement imagines social medicine as an ethos that (i) represents the principles, concerns and objectives of social movements in Latin America, particularly in the struggle against contemporary local capitalism: and (ii) defends the marginalised position of the critical 'medico-social' approaches to health and disease, including the 'Golden Age' of Latin American social medicine and the fundamental principles of the 1848 hygienic movement in Europe. In this way, ALAMES defined local social medicine as the retelling of the emancipatory goals of centuries-long struggles associated with social conditions, and the underlying processes that developed historically to establish the circumstances that make today's continued health inequities possible.

III. A BRIEF HISTORY OF WESTERN SOCIAL MEDICINE:

a) THE EARLY EPOCH IN SOCIAL MEDICINE:

The chapter will now explore a brief history of social medicine to contextualise the thesis further, taking its starting point from Michel Foucault as a foundational scholar analysing modern medical practices in western liberal societies. In 1974, Foucault unveiled the roots of medical epistemology of eighteenth-century Europe through a series of lectures delivered at the Institute of Social Medicine of the Universidade do Estado do Rio de Janeiro, Brazil. The lectures were published in the journal *Educación médica y salud* with the titles: *The Crisis of Medicine or the Crisis of Anti-medicine* (1976), *The History of Medicalization* (1977) and *The Incorporation of the Hospital in the Modern*

Technologies (1978). Interestingly, the English translation of the 1977 publication is 'The Birth of Social Medicine' (Foucault, 2001c), displacing the emphasis in the title that the Latin American publication gave to the medicalization process. Though the contents of both documents are the same, this slight difference flags the views on social medicine of the authors at the time. English translators seemed to consider Foucault´s work directed explicitly to a genealogy of social medicine in which the process of medicalization and social control was a given. In contrast, Latin American scholars understood social medicine to stem from a tradition of thought that differed from the medicalization commonly attributed to modern medicine. In the latter view, the genealogy Foucault offered was not one of social medicine *per se*, but rather a genealogy of medicalization in modern medicine (conceived as being 'social' by English authors). This section will therefore explore the hallmark features of *the social* attributed to the emerging modern medical epistemology in Europe during the eighteenth and nineteenth-century.

Foucault (1976) notably linked modern medicine with the rise of the eighteenth-century European nation-state. The shift from the authoritative power of monarchies to the state regime also turned the individual body into an instrument for the economic growth of nations. Consequently, Foucault explained that the state sought to ensure the care of each person as part of the role of governing life. The newly-born concern for the government of the body enabled the emergence of 'assemblages' of power aimed at managing individuals. These devices included prison, the asylum, urbanicity, educational institutes and other regulatory bodies (Foucault, 1977; Collini, 1979; Donzelot, 1980; Rabinow, 1989; Corbin, 1990; Escobar, 1994; Rose, 1999; Isin, 2002; Donzelot and Gordon, 2008). In this context, Foucault located the expansion of the medical gaze to domains beyond the clinic, and towards *the social* sphere, in what is known today as 'public health.' Following his work, two processes were characteristic of the extension of the medical gaze: the science of the state, and the transformation of the hospital into a knowledge-generating institution.

According to Foucault, the science of the state was attributed to the *Staatswissenschaft* in Germany that enabled the emergence of state medicine as the body of medical authorities fit to construct knowledge about the vitality of a population (Foucault, 1977). By the mid-eighteenth century, the political machinery of the Prussian empire stifled efforts for a unified state that left provinces unstable for the rise of industrialization, and vulnerable to recurrent conflicts with neighbouring states. In an attempt to overcome the region's socio-economic stagnation, the bourgeoisie created

alliances with the political elites to make available labour force and resources to better organize society through the emerging idea of the 'modern state.' Aligned with the so-called 'mercantilist policies' of the eighteenth century (Foucault, 1977:40; Rosen, 2015:55), the notion of the modern state was grounded in the conviction that the socio-political and economic supremacy of a nation depended mainly on the well-being of its population. In addition, the optimal functioning of its people could not be separated from the performance of the individual body acting within the broader social corpus. As Rose wrote: "(…) the construction of a well-ordered political machine and an enlightened administration depended upon the knowledge of the state of the population" (1985:42). Foucault concluded that the wealth and power of the nation as the basis for social policy marked the proper conditions for the development of population statistics to help acquire the knowledge of the population, mainly in the form of birth and mortality rates, life expectancy and fertility rates (see also Porter, 1986; Daston, 1988; Rusnock, 1990). In the process, statistics as the science of the state was established in Europe during the rise of modern states (Rose, 1985; Hacking, 1990; Reubi, 2017).

Foucault explained that Prussia uniquely optimized the use of statistics by turning the informative nature of data into multiple interventions. As state science developed, institutions came into being, crystallizing new forms of government in the kingdom, and creating the *Medizinischepolizei* or medical police (Rosen, 1953; Lesky, 1976; Risse, 1992). Advocated by pioneer Johann Peter Frank in 1766, the *Medizinischepolizei* extended the *Staatswissenchaft* from registering mortality to observing the natural history of diseases through hospital and medical records (Rosen, 1953; 2015:87-90). The information was forwarded to state ministries, which both systematized the analysis and regulated the methods of collecting the data. The medical police, therefore, constituted a body of subordinated medical expertise that constructed knowledge about the population for the centralized administration of the social body.

Whereas Foucault suggested that medical registrations were mostly interested in phenomena such as epidemics, Rosen argued that the analysis of health problems in community life constituted a foundational element in the control of the social corpus. According to Rosen, the new social role of medicine through population statistics yielded a form of enlightened absolutism known as 'state medicine' (2015:71). State medicine was recognised by scholars to be the material and intellectual precedents of the nineteenth-century notion of social medicine, found in both the modern nation-

state and the preponderance of statistics in the study of 'the social.' The specific forms of surveillance embodied by *Medizinischepolizei*, however, would not withstand the new democratic ideas in Europe stemming from the French revolution. As Rosen concluded, the system of state medicine advocated by Frank and his contemporaries was never fully applied, and remained an idea outdated for its time. The seed of state medicine, nevertheless, was planted, and would soon reap fruits relevant to the modern medical style of reasoning.

Foucault identified a second process characteristic of eighteenth-century medicine: the transformation of the hospital from an institution for the moribund, to an apparatus of medicalization (1973; 1978; Ackerknecht, 1967). Until the end of the eighteenth-century, the history of care practices for the sick were divided between formal medicine, and hospital care (Coleman, 1982; La Berge, 1974). Rather than the provision of therapy to cure diseases, hospital care consisted of secluding the sick until their inevitable death, and separating the poor, deviant and immoral from the rest of society. Foucault explained that the fundamental role of this institution was to protect the population from the dangers of the ill and abnormal, represented through their bodies. Consequently, the management of the hospital was mainly a charitable service provided by religious personnel, whose real concerns were the spiritual needs of the dying, the peaceful transition towards death, and the salvation of souls before the end. Medics rarely appeared on the wards, and when they did, it was only to support severe cases. The reason, according to Foucault, involved the ethos of formal medicine at the time, which devoted knowledge and practices to herbal recipes and orthopaedic interventions, and directed efforts to subgroups who could afford to pay care. Consequently, hospital experience was excluded naturally from formal medical training at the time. With regard to the pre-modern ways of thinking health and disease, Foucault wrote:

> *"The intervention of the medic on the disease revolved around the concept of crisis…The crisis was the moment in which the patient faced his healthy nature and the evil that afflicted him. In this fight between nature and disease, the medic was meant to observe the signs, predict the evolution and favour as much as possible the triumph of health and nature over the disease…In this fight, the medic played the role of interpreter, referee, and ally of nature against the disease." (1978:63)*

Foucault saw formal medicine as following an individualistic rationale, whereby the medic established a direct relationship with the sick person to assist against the disease that originated outside the body in its independent existence. This rationale traced back to medieval medicine, and

continued well into the eighteenth-century until the introduction of disciplinary practices for in-hospital care. Late in the century, a series of inquiries on the status of hospital care in England and France considered the potential of systematic surveillance and management of space as techniques to optimize the performance of the institutions (McKeown and Brown, 1955; Greenbaum, 1975; Crosland, 2005; Rosen, 2015:75). To 'purify' the hospital from the societal threats that resided there, (Foucault, 1978:63), the institutions integrated new regimes of administrating bodies that had already been advanced by the military and maritime economy since the seventeenth-century (Rosen, 2015:70; Morris, 2018). The therapeutic effectiveness of practices at hospitals was based on the permanent monitoring of cases, the classification of ailments, the sorting of bodies, and the singularization of patients for examination.

Foucault suggested that the success of the emerging hospital discipline in controlling disease and death redirected the gaze of formal medicine from private practices to hospital care, enabling the medicalization of the institution, and its integration as a site for clinical therapy (also in Rosenberg, 1987; Stevens, 1989; Sturdy and Cooter, 1998). The emerging therapeutic hospital embodied the individualization of modern medicine by isolating patients in single beds, establishing physical measures like room temperature and ventilation, prescribing courses of actions for the individual, keeping registration of daily affairs, and comparing information between institutions. The introduction of these practices created the scaffold for the constitution of the individual as the main object of study for medical epistemologies in subsequent centuries. Foucault suggested the new amalgams of knowledge from disciplinary and regulatory regimes transformed the ways of thinking about health in medical epistemology. The modern version of medicine that emerged located diseases in the surrounding environment that could now be controlled through the governance and subordination of bodies. The emerging 'medicine of the environment' (Foucault, 1978:68) changed the meaning of nature itself from the state opposing illness, to the constitutive part of illness itself through the contagions found in the elements of water, air, soil/space and food (Woodward and Richards, 1977; Porter, 1985; Porter and Porter, 1988; Fissel, 1991a, b; Wear, 1992).

Foucault explained that the final decades of eighteenth-century Europe corresponded to the shifts in medical epistemology through the analysis of 'the social' as the ill-environment associated with unhealthy living and working conditions. Nature not only had the potential to harm individuals in the hospital, but also to damage the social corpus as a whole outside of institutions. This made the

population, conceptualized as the aggregation of individuals that comprised the nation's productive force, central to political stratagems. As Rosen explained, processes like the industrial revolution and the transformation of governments from monarchies to civic organizations enabled multiple movements for the betterment of living and working conditions in Europe (2015:80-87). Consequently, a wealth of reports and publications were devoted to recognizing the physical geography and natural history of subgroups across Europe, Asia and the Americas. Characteristically, the publications testified to the move towards understanding epidemics and endemic diseases, not as entities in themselves, but as extensions of the climate, food, housing, sanitary space (sewage, distribution of space, cleanliness of cities), different occupations, and customs of the inhabitants. The use of statistics to infer causal associations between environmental factors and population health was commonly referenced in the publications, and scholars established the notion of social medicine as preceding and generating these studies. These scholars included Louis-René Villerme, Bernardino Ramazzini, John Snow, Thomas Percival, Richard Mead, Edwin Chadwick, Thomas Southwood Smith, William Farr, Johann Peter Frank, and Max von Pettenkofer. For the first time in the history of western civilization, medical epistemology considered health as determined by the social conditions of life and resulting in the economic effectiveness of the population (Lemke et al., 2011).

b) THE CONSOLIDATION OF SOCIAL MEDICINE AS A DISCIPLINE:

Though the value of environmental causality in health is unquestionable, social medicine literature today is grounded on the basic premise that health and disease have additional dimensions. As Rosen explained: "Nowhere does human disease occur as ´pure nature´; instead, it is ever mediated and modified by social activity and the cultural environment which such activity creates" (1947:674). Rather than clarifying the factors that impact health and disease, many scholars of contemporary social medicine invested in demystifying the underlying social processes, dynamics and forces that constituted the conditions that affected population health. At the heart of current social medicine, therefore, stands the multiple ways in which 'the social' is understood in health epistemologies. Though authors have suggested the social as a dynamic, mutable and variable notion, made up of the contingencies of the context in which the studied phenomena are embedded (Adams et al., 2019), exploring this term in the history of social medicine yields ruptures through which contemporary scholarship came to be. The distinction is between 'the social' as a constant variable

or a rigid bundle of factors in the background of society – and 'the social' as the processes, dynamics and/or forces of embeddedness, captured by the social sciences of health, and determining multiple aspects of population health.

This section explores the parallel views of 'the social' and its implications on the concept of social medicine in the nineteenth-century. During this time, European modern medicine consolidated, mainly by expanding the medical gaze from the therapeutic hospital to the public sphere (Ackerknecht, 1948; Rosenberg, 1962; Foucault, 1977; García, 1994; Porter, 1998; Rosen, 2015). In the development of the public sphere, sanitation reports paved the conditions for the introduction of social medicine as a way of understanding population health, revealing two essential features. Firstly, the reports flagged the need to recognise the inescapable nature of the surrounding environment in the determination of a population's well-being. As described earlier, the progression of health research in the nineteenth-century made evident the appalling living and working conditions that resulted from the rise of industrialism across Europe. By relying mainly on statistical studies, modern medicine was predicated on the basis that the social*,* defined as environmental factors that impacted health, was integral to conducting proper population health analysis. Secondly, various publications extended beyond the environmental causation, and attempted to theorize the mechanisms through which ill-environment emerged from standing social asymmetries, the predominant culture, the democratic or political processes, and the economic regimes that organized societies. Authors of this second strand aimed to construct comprehensive theories of health that explained the statistical correlations found in the reports. Though distinctive, these two essential aspects, featured in the reports, complemented ways to nurture the epistemology of health and disease in modern medicine. To explain these approaches further, this section begins with the industrial revolution in Europe and its impact on the development of medical thinking in the nineteenth century.

Rosen is particularly helpful when attempting to understand the emergence of the industrial economy in nineteenth-century England and its impact on health (2015). He identified how the exponential rise of epidemics and peaks of endemic diseases in urban populations paralleled the establishment of factories across cities. Though an earlier emphasis had been on impact of the social environment on population health, Rosen explained that industrialism motivated nineteenth-century research to uniquely connect: "…poor health with deleterious social conditions based on

numerical data" (2015:92). The mass migration of rural population to the factories in search of work opportunities precipitated a crisis in urban growth. Local authorities lacked the capacity to manage the incoming crowd of people. Cities had no housing infrastructure to sustain the masses who clustered around the iron and coal industries, nor did they possess the proper organization of space for the provision of sanitary conditions. Also documented by Wohl (1983), cities and larger towns at the time were particularly polluted, with inadequate provision of sewage or clean water, streets frequently polluted and foul-smelling, roads unpaved, alleys dark and dangerous, and housing overcrowded and unstable. Outbreaks of cholera, smallpox, diphtheria, bubonic disease, typhus, and tuberculosis were frequent, leading to clusters of detrimental population well-being, and little productivity by the working masses.

Parallel to the foul conditions of cities, the organization of society through the dominant doctrines of economic liberalism enabled a high pitch of capitalist activity, and gave rise to a new social class: the wage-earning industrial proletariat (Coleman, 1982; Evans, 1987; Sanders, 2000). As Rosen explained (2015:109-16), the English economic liberalism strengthened the value of private property, permeated the acceptance of social atomism, and consolidated practices like labour exploitation and child abuse. The new industrial middle class advocated against social protections for the wider population, viewing any system of poor relief as an obstacle to the supply of cheap labour and high productivity. The oppressive dynamics of labour in industrialism, coupled with the human costs of living and working conditions (including the rise of premature adult mortality), created a clear divide between the lower class and the middle-class bourgeoisie. The divide developed into a social conflict that materialized in the so-called ‘Sanitary Movement’ (Lilienfeld, 1977; Hennock, 2000; Litsios, 2003), oriented to the betterment of conditions but lacking a profound analysis of the structures and dynamics in place that enable the conditions in the first place. As Rosen observed: "Such an intellectual environment (the English economic liberalism) was hardly conducive to analyses of the social aspects of health and disease (…)" (1947:686).

Riots and uprisings in Britain quickly shaped public opinion, and led to different forms of societal action. On one side, independent authorities and agencies established new services and institutions to provide for immediate improvements in living conditions. These agencies were often the result of the amalgamation of non-state actors into social movements of cooperative endeavours, fully supported by government authorities. The Manchester Board of Health established in the wake of

the typhus fever, run by pioneer Thomas Percival, and the provision of water by private companies are cases to consider in the context of Britain, according to Rosen. Though somewhat effective, this approach was not sustainable as social conditions required large-scale changes to satisfy both the needs and the requirements of the growing population. The new industrial economic system also demanded even more workers to be brought into the factories. Consequently, Rosen continued, local governments used legislative power to promote research that documented the circumstances and advance additional preventive measures. The Poor Law of England illustrates this case (Hodgkinson, 1967; Midwinter, 1969; Watson, 1969). Formerly a law of relief for the indigent in the seventeenth-century, in the 1830s the Poor Law was transformed by a Royal Commission to optimise the regulation and action upon pauperism. Edwin Chadwick was central to the work of the Commission, bringing evidence that associated disease with the higher burden of poverty rates, and advocating for emphasis on disease intervention as a social policy. By 1836, the Commission established the Bureau of Medical Statistics and was involved in passing the Registration of Births and Death Act – both efforts to tackle environmental causation, disease prevalence, and improve the health of the population. The attention of nineteenth-century medical epistemology on the working and living conditions of the poorer classes was explicitly tied to the exponential rise of urbanization, and the decreased influence of state rationality - a phenomena also documented in France as *Hygiene Publique* (Foucault, 1977; La Berge, 1984; Hildreth, 1987; Ackerman, 1990).

This literature suggests that concerns about environmental conditions in the nineteenth-century constructed the view of 'the social' as a bundle of external factors that explain health phenomena. The trend is followed by the myriad of publications throughout the second half of the nineteenth-century by authors like James Philips Kay, Richard Oastler, Charles Turner Thackrah, Peter Gaskell, and William Farr (Eyler, 1979; Porter, 1995). Most of these authors devoted efforts to the analysis and action upon the abhorrent labour conditions of the working class as the primary determinant of diseases. Notably, their work rarely associated the improvements of bad conditions with the re-organization of socio-economic dynamics or forces. As Rosen (2015) explained, the economic and political climate at the time was firmly against the possibility of any societal change, because the wealthy and powerful classes still upheld their positions as divinely appointed. Therefore, the motivation to make social conditions a matter of scientific inquiry did not constitute real efforts to transform the society. Instead, the commissioned reports mostly expressed the empirical curiosity of modern scholars and politicians – with limited implications beyond theoretical reflection. Rosen

argued that the constitution of social medicine as the field analysis social processes impacting health still required the elaboration of theories to strengthen health epistemology.

In contrast with the lack of social theory by English reformers, the notion of 'social medicine' arose from the 1848 German sanitary movement through the exemplary cases of Rudolph Virchow, Salomon Neumann and Rudolf Leubuscher (Ackerknecht, 1953). Rosen (1947) noted that although industrialism was briefly delayed, the same socioeconomic conditions seen in Britain and France also developed in Germany. Industrialism led to marches, barricades and social turmoil. Inspired by the Paris February Revolution, Virchow also joined the sanitary movement and was deeply convinced about the need for societal action to secure changes in the living conditions of workers. Through the works of Louis-René Villermé and Jules René Guérin in the decade prior to the sanitary movement, Virchow became familiarized with studies that linked societal conditions and health in France and Germany. Rosen suggested that, rather than exclusively focusing on research, the upheaval of the revolts and the prolific space for philosophical thinking in Prussia enabled Virchow's inclinations to take a critical approach to social inequities, best materialized in the famous slogan: "Medicine is a social science, and politics nothing but medicine on a grand scale" (1848; see also Ackerknecht, 1932). Virchow not only adhered to the search for the social basis of health and disease, but also elaborated a complex mesh of principles and theories which proved foundational to the constitution of social medicine as the social sciences of health. The rise of social medicine as a field of research and political action in the nineteenth-century was nurtured from the social theory of scholars like Virchow, providing a comprehensive explanation of how social conditions impacted population health. Rosen explained:

> *"As an extension of his views on the relations of medicine to society, Virchow developed a theory of epidemic disease as a manifestation of social and cultural maladjustment…these "artificial" epidemics occur not only as a result of social contradictions, but also as significant manifestations of the historical process. Such outbreaks of disease occur at nodal points in history, during period of political and intellectual revolution." (1947:679-680)*

For Rosen, theories of epidemic diseases developed by Virchow and his contemporaries were rooted in three principles: Firstly, socioeconomic circumstances are conducive to epidemics, carrying equal explanatory weight as any other biological model and constituting essential elements of the scientific inquiry pertaining health and disease. Virchow perceived conditions to be man-generated,

insofar as they emerged from deficiencies developed through the historical trajectory of societies. This included social asymmetries, oppression, labour exploitation, and so on. In this way, the use of the term 'maladjustments' in the quote signalled the conceptualization of 'the social' as an explanatory model that involved a cascade of events, series of relationships, a spread of responsibility, and intricate functions of an elaborate phenomenon that underlay ill-conditions. Rosen added that, for Virchow and his contemporaries, socioeconomic conditions were instrumental causes of the disease, driven by other vital causes associated with the political and social organization of a society. Second, as a result of the association between socioeconomic conditions and population health, German reformers argued that both instrumental and vital causes of disease were direct concerns of society as a whole. The emergence of this concern, Rosen noted, was embodied in the reformer's requirement for the state to protect the nation's health by transforming society as needed. Lastly, given the complexity of social conditions, and the state's responsibility for population health, German reformers advocated for the equal relevance of medical and social interventions for the betterment of the population's health.

The analysis of nineteenth-century modern medicine above recognises different conceptualizations of 'the social,' and acknowledges the evidence of their co-existence in the same way of thinking about health and disease during this time. Virchow represented a pioneering attempt to view social medicine as social sciences of health, mainly linking population health to societal processes. His efforts also supported the need for reliable statistics to measure population health. As Rosen added, Salomon Neumann was also a strong advocate of quantitative methods in this regard. Rather than holding opposing views on the relationship between society and health, the derivation of causality taken from medical statistics – combined with demystifying causal associations through the analysis of social processes – was integral to the foundational principles of bringing social medicine into the social sciences of health.

Though the German reform movement of 1848 was highly influential in the affairs of Europe, the objectives of the revolution failed to materialise, leaving the principles and propositions as mere intentions. The ideas advanced by Virchow and Neumann were transformed into narrower political objectives that were feasibly accomplished by strategies like the Bismarck healthcare system for workers. Rosen highlighted that: "To most Germans after 1871, the movement of 1848 was something of a strange past. The national aspect of the movement was still recognised but the social

ideas had been abandoned" (1947:708). Rosen noted that the rapid development of the field of bacteriology through the scientific work of, for instance, Robert Koch and his discovery of the tuberculosis bacillus quickly dominated the main ideas in medicine in the decades that followed. Consequently, scientific epistemology focused on the natural history of the disease, enabling the natural sciences in health and medicine to dominate the field of health. This phenomenon gave way to the empiricist era of sciences towards the end of the nineteenth- and beginning of the twentieth-century (Strasse and Chadarevian, 2011). The promise of natural sciences, as shall be explored, included the depoliticization of health to standardise practices, the enhancement of clinical effectiveness in medicine, and the unprecedented prestige of modern healthcare as the most reliable way to make sense of population wellbeing.

c) LATE NINETEENTH-CENTURY UNTIL THE 1970s:

Though the failure of the 1848 movement left the recently-established social medicine in apparent demise, attempts to join together statistics (suggesting causation) and social studies (explaining the processes underlying causation) found successors in the works of Edward Reich, Max von Pettenkofer, Alfons Fischer, Alfred Grotjahn, and Armand Meynne (Rabson, 1936; Labisch, 1985; Weindling, 1986, 1987; Willich and Berghofer, 2013). These writers followed the principles proposed by the earlier German reformers. However, rather than social medicine, they reframed the field as 'social hygiene.' This change in concept is relevant as contemporary literature seems to present two views on social hygienism that are relevant in the trajectory of social medicine as twentieth-century social sciences of health. Firstly, furthering the historical narrative of the social sciences of health, social hygienism represented the advancement of social medicine through the work of authors such as Alfred Grotjahn, Ren*é* Sands, John Ryle, and F.A.E. Crew. This strand distinctively followed the earlier complementary approach of social medicine, seeking to explain the social processes underlying population health (Rosen, 1948; Porter, 1999a, 2002, 2006). Secondly, social hygienism was also presented as the management of individual conduct and the reshaping of moral deviations characteristic of public affairs in late nineteenth-century in countries like England. The second approach focuses on the emergence of normative claims in liberal societies, and the shaping of individuals into special kind of subjects that endeavour specific political objectives (Rose, 1985; Armstrong, 1983; Brandt, 1987; Hunt, 1999; Damer, 2000; Laite, 2008; Egan and Hawkes, 2009). The elements and relevance of both perspectives are the topics of this final section.

Rosen provided a comprehensive revision of Alfred Grotjahn as the main exponent of European social hygienism in the early twentieth-century (1948). For him, Grotjahn uniquely struggled for the systematic use of social sciences in the study of population health, aiming to construct a theory of social pathology that could account for the correlation between worst health outcomes, and harmful social conditions among the poorer social classes. Grotjahn preferred the term 'social hygiene' due to the association social medicine acquired with the establishment of the Bismark-model of healthcare system in late nineteenth-century Germany. To Grotjhan, social medicine as healthcare inadequately narrowed the field to a topic of insurance coverage, leaving little room for the critical analysis of causal mechanisms in population health that was originally intended by German reforms. According to Rosen, the committed public health scholar insisted on the study of additional dimensions in health phenomena that reconstructed the realities of society and culture accurately. Grotjahn understood these dimensions to be social structures, and resulting relationships that emerged from the historical contingencies in the trajectory of a particular context. He believed the resulting structures organized society in a specific way, and directed individuals to certain life options. As such, Grotjahn advocated for the integration of diverse academic disciplines to study the complexities of health phenomena, including demography, anthropology, economics and sociology. In line with the Germans reformers, his view equally considered biologic and social causes in the aetiology of health and disease.

Following Grotjahn, early twentieth-century authors also argued against reductionist approaches to health, particularly from: (i) the views limiting medicine to the practices in healthcare systems, and (ii) emerging epistemologies claiming exclusive status over the construction of knowledge (see debates on *germ theory* in Latour and Woolgar, 1986; Arnold, 1988; Leavitt, 1990; Kamminga and Cunningham, 1995; Weindling, 2000; Worboys, 2000). According to Rosen, social hygienism scholars focused on the evaluation of diseases resulting from conditions in society (social diagnosis), the social basis causing ill-health (social pathology), and the appropriate therapy and prophylaxis from non-clinical interventions. Medical statistics remained at the forefront of the scientific method of research. Two authors embodied the centrality of social theory for understanding the social basis of health and disease. On one side, Ludwig Teleky in Austria sought to develop insights into the relationship between health and living conditions through the concept of 'social class' (Terris, 1957). Teleky uniquely examined the inequalities in population health resulting from the social position

groups held within the established structure of society, seeking to tackle them through social welfare policies. On another side, Ren*é* Sand in Belgium worked to establish social medicine as an academic discipline, after he was appointed professor of Social Medicine at Brussels University in 1945 (Sand, 1952; Porter, 2002). By emphasizing new approaches in prevention, social economy, and medical sociology (Zylberman, 2001, 2004), Sand advocated for the inclusion of medical statistics, social surveys, and qualitative studies in medical sciences, aiming to increase the interest of physicians to collective life.

Britain also served as a case worth mentioning on the first view of social hygienism as a type of social science applied on health research. According to Porter (1999, 2002, 2006), the interwar years in Europe enabled various conditions that favoured social theorist to expand their views to the health field in England. Social policies at the beginning of the new century had improved the nation's socioeconomic conditions, increasing the population life expectancy significantly. As a result, a first epidemiological transition developed in the country, witnessing the decrease of infectious diseases parallel to the exponential increase in non-infectious chronic illnesses. According to Porter, social medicine at the time offered the possibility to bring together clinical medicine and social sciences, to provide the intellectual resources required in the study of the emerging health phenomenon. In addition, the Great Depression of the 1930s brought about significant challenges that were initially met with uncertainty. The potential consequences of the economic crisis on the welfare of the British population prompted a new wave of research that sought to clarify the relationship between health and society. The resulting reports, such as the Interim Report by Social and Preventive Medicine Committee of the Royal College of Physicians of London in 1943 (Pemberton, 2002:343), and the Report of the Inter-Departmental Committee on Medical schools by Sir William Goodenough in 1944 (Armstrong, 1983:39); recommended the institutionalization of social medicine in medical schools to enhance the effectiveness of social policies and health interventions. These combined factors led to the establishment of social medicine institutes across the United Kingdom, including Oxford University under the leadership of John Ryle, the University of Edinburgh with F.A.E. Crew as chair of the Public Health and Social Medicine Department, and the University of Birmingham with Dr. Thomas McKeown at the forefront (Weindling, 1999; Gillespie, 1999; Zylberman, 2004; Porter, 2006).

The newly-appointed chairs of these social medicine institutions made remarkable contributions, introducing public health as a discipline to British medical schools in the first half of the twentieth century. As Porter explained (2002), scholars emphasised the need to change the scope of research from individual analysis to population scale in order to capture group differences. This shift in the object of study implied the application of new methods in medical schools, such as statistics and surveys, and attempted a dual approach of curative interventions with preventive measures to tackle social pathology. The study of the environment broadened to encompass the physical atmosphere (through the natural sciences) as well as society's economic, occupational, educational, nutritional and psychological backdrops. Porter highlighted the integration of social medicine in medical education, which particularly sought to imagine new ways of organising society through a medical epistemology that brought the social and medical sciences together. While British accomplishments in social medicine were undoubtedly relevant to the history of western medicine, the extent to which this strand embraced the principles of German reformers is questionable. As Rosen wrote regarding Crew's work: "Although the word 'social' is used repeatedly, there is no effort to define precisely what is meant by 'the social'" (1947:725). He also noted that by 1945, the Institute of Social Medicine at Oxford University did not have sociologists, anthropologists or economists on its teaching staff, making the claims for the integration of disciplines somewhat paradoxical.

By contrast, the second view of social hygienism as behavioural sciences took its cue from the British context at the end of the nineteenth-century and the beginning of the twentieth. In revising the social conditions that made the rise of psychology as a discipline possible, Rose (1985) critically analysed the historical discontinuities of the scientific discourse in nineteenth-century Britain. He observed that authorities in the region traditionally framed discourses about population health as issues of perversion, vice and immorality to establish a regime around the conduct of the body from childhood until death. Under these discourses, the moral conduct of individuals (including habits such as vagrancy, crime, prostitution, and inebriety) depended on the mental capacities of the person, and manifested in the body through disease and madness. Medical knowledge, as an emerging positivist science, proved to be pivotal in the management of bodily conduct on two fronts. First, medical epistemology served as a scientific basis for certain truth-claims associated with social standards of living and behaving at the time (neatness, modesty, compliance, and regularity of conduct as the Victorian model of ethics and morality). And second, medical

epistemology enabled the possibility of 'moral therapy', by redirecting conduct through disciplinary devices like constant surveillance, hygienic habits and the redistribution of bodies in space.

For Rose, the above sense of social hygienism during the nineteenth-century England grew from the development of the moral discourse in the history of modern medicine. In this way, he continued, rather than illnesses deriving from the socioeconomic model, health authorities interpreted the high prevalence of diseases of English industrialization as pertaining to the corruption of social habits, and the contagious nature of demoralisation. Given that the greater population affected were the poor, feeble-minded, and vulnerable, Rose argued that immorality came to be associated with pauperism, the mentally disabled, and socially deviant. Demoralisation was therefore perceived to be acquired through mimicry of ill-conduct, by way of the sharing of public space. 'The social' in this version of social hygienism is not the socioeconomic, political and cultural processes underlying ill-conditions, but rather the space in between people where individual behaviour is stylized, regulated and reformed. As a result, in order to halt the spread of degeneracy through the transformation of the social milieu, the clinical gaze shifted from hospital institutions to the irreligious, insubordinate, idle, and violent individuals.

Armstrong (1983) complemented Rose's study by revising the medical practices of twentieth-century 'neo-hygienism' in Britain. In essence, Armstrong argued that various medical devices implemented in the wake of the new century enabled the introduction of the 'community' as a term capturing a new locus of disease in the population. Satellite offices for the dispensation of medications (known as *dispensaries*) were instituted into public policy in the early twentieth century, and used as the basis for the subsequent national healthcare system. Dispensaries enabled medical professionals to continually monitor people from viewpoints outside traditional institutions, and nearer to community dynamics. By taking the medical gaze closer into the microphysics of everyday life, the dispensary sought diseases in "(…) the spaces between people, in the interstices of relationships, and in the social body itself" (Armstrong, 1983:8). The scrutiny of the patient's conduct provided optimal conditions for the emergence of new medical models, including the creation of general practitioners, the proliferation of local health centres, and the rise of medical practices (such as follow-ups and home-visits) to capture family histories and plot social networks. For Armstrong, the refinement of surveillance represented a stark shift in medical

epistemology, moving from the management of the physical environment (an issue pertaining public health) to the governance of social life and relations (the domain of social hygiene).

According to Armstrong, the new hygiene also brought about an innovative surveillance technique that further transformed the essence of modern medicine: the social survey. In attempts to capture the bundle of variables pertaining to individual habits and family conditions, the social survey uniquely introduced the study of disease morbidity, reviving statistics from the seemly stifling efforts of mortality measures. The morbidity survey evidenced the progression of diseases as the response to harm within the physiology of the body. This finding challenged the traditional ontological dichotomy between normal and pathological, displaying the arbitrariness of parameters defining illness and questioning many dominant truth-claims.

Additionally, the technologies of the social survey helped reframe the predominant perspectives about patients. Before *neo-hygienism,* Armstrong explained, medical epistemology fabricated the body as malleable to the power of knowledge and therefore understood individuals as docile entities awaiting the authoritative instructions of health professionals. The idea of bodies as objects in medical practices extended well into the mid-1940s with Goodenough's report on medical education. However, the introduction of surveys during GP consultation permitted a profound insight into the history of patients, including cultural attitudes, social prejudices, everyday challenges, and habitual behaviours. In the acquisition of new knowledge, Armstrong concluded, morbidity surveys made visible the multiple dimensions of human living and thus helped in recognition of patients as subjects by medical authorities. As per Armstrong, the use of surveys fabricated the patient's personality, idiosyncrasy, character and psychological make-up – suddenly granting the individual an identity. In other words, 'the social' of neo-hygienism implied the exploration of all minutiae and singularity of individual behaviour. Putting Rose and Armstrong together, 'social hygienism' in the second view makes the discourse of behaviour and personality a central feature in the development of medical practices during the twentieth-century.

The two perspectives of social hygienism above differed mainly in the causation model that explained the association between social conditions and population health outcomes. While the first view aligned with the social sciences of health by studying processes, forces, and power relationships vis-à-vis the contextual socioeconomic, political and cultural background; the second

view emphasised the role of social conduct, social relations, and individual identity in underlying processes. It may be argued that the two perspectives are not distinctive strands of thinking, but two critical analyses of the same epistemology, given that both views frequently overlapped in the works of the same authors. For example, writing about J.A. Ryle (traditionally associated with the first view), Armstrong explained that his work effectively extended "(…) the interest of public health from concern with the environment to a concern with the social relations" (1983:38). Indeed, Ryle's discourse contained various elements of neo-hygienism highlighted above, as much as efforts to integrate social sciences in health. Additionally, other authors recognised the features of positive eugenics in Alfred Grotjhan's work (Faith, 1987; Willich and Berghofer, 2013) - a field linked to the social hygienic movement in Britain during the late nineteenth century, which later developed independently with the emergence of neo-hygienism (see Searle, 1976; Webster, 1981; Stepan, 1996). In either case, the remarks above make evident the difficulty in dividing social hygienism in two distinctive strands that developed separately.

It is also important to further clarify the narrative of social medicine in the US, due to its close connection to the Latin American social medicine. Similar to neo-hygienism in Britain, various North American authors emphasised their interest on individual lifestyle and behaviouralism as foundational aspects of the research (Rosenberg, 1977; Brandt and Gardner, 2000). Rosenberg argued that the roots of social medicine in America are found in the charitable organizations at the end of the nineteenth-century that sought the betterment of social conditions associated with diseases like tuberculosis, typhoid fever, and venereal infections (see also Terris, 1957; Franco et al., 1991). According to Terris, authors initially sought the integration of the social sciences in the study of health problems, capturing the combative spirit of 1848 social medicine, against the noticeable asymmetries of the growing capitalist system. These authors included Edgar Sydenstricker (Milbank Foundation), Bernhard J. Stern (Columbia University), Milton C. Winternitz (Yale University) and Henry E. Sigerist (Johns Hopkins University), among others. However, various factors of the post-Second World War era, including McCarthyism policies and the Cold War conflict, severely halted the progression of these efforts and inclined scholarly work towards the so-called behavioural sciences. For example, Francis Lee Dunham, senior lecturer of Social Medicine at the Johns Hopkins University, defined social medicine as the application of research on the organization of social habits, and the unveiling of biological characteristics (Rosen, 1947a:726). Henry Sigerist went so far as to consider social medicine an 'attitude' towards illnesses, resembling the behaviourist discourses

of preventivism later applied in Latin America through international developmental policies (Arouca, 1975a). Porter explained the phenomena better when she wrote:

> *"(…) following the Second World War, a new accommodation was achieved within US public health…public health adopted a more biomedical rather than socio-medical model of disease within the preventive philosophy driven by the management of individual risk factors…These frameworks were supported by the development of what Gerald Oppenheimer argued was largely a behaviourist model of clinical epidemiology in the early post-war decades." (2006:13)*

As Porter explained, twentieth century Anglo-American social medicine largely focused on statistical research, examining the correlation between individual behaviour and chronic conditions like obesity (Dublin, 1924), and cardiovascular diseases (Moriyama, 1948; Morris et al., 1953; Oppenheimer, 2005). Though for a brief period prior to the Second World War, US international politics showed interest in the social reforms and welfare policies typical of social medicine (see the Pan-American Sanitary Bureau and the International Health Division of the Rockefeller Foundation in Carter, 2019), the post-war political milieu of McCarthyism and Cold War eventually guided efforts towards individual lifestyles. This left the study of structural determinants of health and socioeconomic, political and cultural processes of health and diseases largely relegated. According to Porter (2018), social medicine after the Second World War became 'tamed' by the growing emphasis on psychological approaches, shifting the conceptualization of 'the social' to individual behaviour, conduct and habits – disabling any emancipatory objectives tied to action upon broader social processes, forces and dynamics. Behavioural sciences reinforced the lifestyle paradigm of health and disease, pivotal in the construction of biomedical knowledge in the US during the second half of the twentieth century (Berelson, 1968; Campbell, 2010; Porter, 1996, 2006).

In the context of Latin America, scholars recognised that the introduction of social medicine in the medical curricula across the region stemmed from the growth of Anglo-American behavioural sciences at the Ford Foundation, Harvard University, University of Chicago, and the Rockefeller Foundation (Franco et al., 1991:35). According to Franco, behavioural sciences in mid-twentieth-century US aggregated other social science disciplines, such as anthropology and sociology. However, he continued, North-American behavioural sciences dissociated individual conduct from the social basis of health, postulating that the necessary changes for the betterment of population health were not actions upon social structures, but rather changes in individual lifestyles and healthy

living. The predominance of individual responsibility emerged as a pivotal aspect of health research, creating an antagonism between the US version of preventive medicine and the rising Latin American social medicine developing in the 1960s and 1970s (Galeano et al., 2011). Echoing the second perspective of social hygienism described above, behavioural sciences in the US was the predominant approach to health phenomena that interpreted 'the social' as a matter of individual conduct.

Though behavioural sciences dominated health research in the US, it was not without exponents of social medicine as social sciences of health. Erwin Ackerknecht is notably salient in the history of social medicine (Rosenberg, 2007). According to Rosenberg, Ackerknecht was well acquainted with Virchow and the German medical reform through his postgraduate studies in Europe. He understood the serious commitment to demystifying the larger patterns of socioeconomic and political development involved in population health, taking in context diseases as indicators of underlying historical events. "Medicine was the master science of man, linking body and society," Rosenberg added, "(…) Social science, as Ackerknecht explicated Virchow's position, was ultimately a subdivision of medicine" (2007:518). Rosenberg observed that Ackerknecht characteristically opposed reductionist models of research in which the rationale and practices of other disciplines (like the natural sciences) were used to examine the social basis of disease. Instead, Ackerknecht approached studies through an integrative, anti-reductionist and centripetal perspective, as an attempt to link the world complexities with the materiality of illnesses (see, for example, his research on malaria in Mississippi, Ackerknecht, 1945). Ackerknecht saw limited benefit in an exclusive focus on medical interventions, and advocated for social diagnosis, social pathology, and social reforms associated with, for example, the dominant liberal political philosophy, market economics, and modern capitalist governments.

This thesis situates precisely at the historical bifurcation between the US behavioural sciences in the discipline of preventive medicine, and Latin American social medicine emerging as a network in the 1970s (later consolidating as the ALAMES association in 1984). Though there is plenty of literature documenting the history of public health in Latin America (Stepan, 1976; Zilvetti, 1981; Marquez and Joly, 1986; Franco, 1990; Yepes et al., 1990; Lowy, 1990; Cueto, 1991, 1994; Merhy, 1992; Illanes, 1993; Birn, 1995; Quevedo et al., 2007, 2008, 2010; García, 2016), no systematic research has critically analysed the Latin American social medicine of ALAMES by emphasizing the role of

social medicine outside North America and Europe. The collective has also not been documented as a situated epistemology, characteristic of the Latin American context in the twentieth-century.

IV. CONCLUSION:

By analysing the history of social medicine through the work of fundamental scholars, this exploration yields guiding themes that will be addressed throughout the thesis. Eighteenth and nineteenth-century medical epistemology enabled the emergence of multiple features fundamental to contemporary social medicine. Firstly, the context of state medicine and industrialism in Europe prompted the study of labour and living conditions in the broader society. The importance of medical statistics and sanitary surveys were recognised as a predominant way of establishing causal associations between society and health. Secondly, the rising responsibility of the government to care for a population's health as part of the modern state was also linked with the growth of social medicine as a research discipline in Europe at that time. Traditional therapeutic devices like the modern hospital morphed into instruments of the state to contribute to the growth of individualized medical practices. The concepts and the tensions brought by this particular way of understanding health and disease became relevant in the critical analysis of the social medicine thought style of the ALAMES collective. Lastly, the rationale and practices in European social medicine were linked to the emergence of the working class, enabling a different understanding of social factors as determinants of health and the disease process. As described, views on social medicine differed, between the conceptualization of 'the social' as variables in the background of the context, vs. 'the social' as processes, dynamics, and relationships underlying the socioeconomic models that determine population health. Differences, as shall be explored in this thesis, are pivotal to the differentiation of the ALAMES thought style.

The revision of social medicine that progressed through the nineteenth and twentieth-centuries further clarified different core principles in social medicine, which Latin American social medicine also promotes. More specifically, the 1848 sanitary movement in Germany advanced various theories in health, where the social sciences were applied to explain underlying mechanisms through which ill-conditions of labour and life came into existence. The consolidation of social

medicine, therefore, was founded on the exploration of research beyond the mere establishment of causal relations between the environment and population health; it came into being by scrutinizing the role of social processes, underlying dynamics, and internal relationships that developed throughout the social trajectory of the context. Additionally, the distinct conceptualization of 'social hygienism' added another layer of complexity in differentiating between behavioural sciences and social sciences in health. The next chapter will explore how the behavioural sciences were introduced to Latin America as part of the developmental policies in the 1950s and 1960s, post-Second World War, when social medicine was subordinated to the growing psychological approaches in health. In response to the advancement of behavioural sciences, scholars from Latin American social medicine rediscovered the tradition of the 1848 sanitary movements and social sciences in health (Virchow and Neumann), and the continuation of these principles through other scholars such as Grotjahn, Sand, Sigerist and Ackerknecht.

The history above links to ALAMES directly through the Seminars in Medical Education by the PAHO in association with different philanthrocapitalist organisations, which drastically expanded preventive medicine in Latin America. As a response, various scholars across the region united to refocus medical epistemology to the analysis of socioeconomic, political and cultural processes determining population health - a feature explored in this chapter through the profile of social medicine pioneer Juan Cesar Garcia and the development of ALAMES pre-cursor in the *Latin American social medicine network.* The network interestingly incorporated social theory within health research, particularly from Marx's historical materialism, Foucault's genealogy approach, and other poststructuralist authors. ALAMES itself was established through academic programs on social medicine (UAM-X and UERJ/IMS), and the Cuenca I and II meetings. Interestingly, rather than the search for academic excellence through peer-review publications, international recognition of higher education, or editorial management of high impact journals; ALAMES mainly focuses on its political relevance and articulation with grassroots movements. To justify this positionality, the thought collective grounds its epistemological development on both the oppositional politics of Latin American social medicine 'Golden Age' and the historical links with European social medicine. The purpose of the introduction, therefore, was the thorough contextualisation of the narrative to position the reader for the analysis encountered ahead in the thesis.

CHAPTER 2

METHODOLOGY OF THE THESIS

I. INTRODUCTION:

Social medicine is a field of research constituted by an assortment of rationales and practices, whose commonality is the fundamental concern for the relationship between society and health. Scholars in the field view health and disease as complex phenomena that require concepts, categories, explanations, and methods that extend beyond the limits of the biomedical paradigm (Anderson et al., 2005; Holmes et al., 2014; Stonington et al., 2018). The imperative to apply social studies to health is relevant because contemporary western liberal societies tend to grant biomedical research superior status over constructing knowledge regarding health and diseases (Farmer et al., 2006; Cueto, 2013; Aggleton and Parker, 2015). Social medicine cannot be understood when separated from the critique to biomedical exceptionalism, the scrutiny of the technical, reductionist, and specialised clinical practices, the re-evaluation of medical education, and efforts to make clear the social basis of health and disease (Oakley, 1997; Zylberman, 2004; Lowy, 2011; Adams et al., 2019).

Charles Rosenberg, Professor of History of Science and Medicine at Harvard University and a respected figure in the social medicine literature explained: "In social medicine, disease as it occurs is not simply an inevitable and random biological phenomenon but, in part, an outcome of manmade - and thus culpable, mutable, and consequently reformable - social circumstances" (2007:531). The transformation of social circumstances found in much of social medicine scholarship applies in two ways: the constitution of more just societies, where the continuing power of health disparities motivates action to defend the poor, sick and disenfranchised; and the search for epistemic egalitarianism in the co-existence of multiple scientific epistemologies which contribute to the highest accuracy possible in the understanding, interpretation and action upon population health and disease.

The concept of social medicine derives from the critical analysis of industrialism in nineteenth-century Europe, intimately tied with the history of social policy. Proponents of social medicine focused on the emerging working class and sought to improve their conditions through social welfare reforms. From industrial working conditions, the field broadened its scope to other societal areas, through various practices which some conceptualise as public or social 'hygienism' (Rosen, 2015). It called on the state to take a substantial role in developing and regulating healthcare systems and societal institutions to serve the collective needs of national populations. In recent times, heightened interest on the social determinants of health have revitalised the views and objectives of social medicine as pivotal to global health (Wilkinson and Pickett, 2010; Ottersen et al., 2014; Kawachi et al., 2014; Marmot 2015a, b), the critique of universalising truth-claims (Krieger, 2001; Almeida-Filho, 2004; Anderson, 2019), and the boundaries between the local and the global (Kasper et al., 2016; Adams et al., 2019; Ortega and Behague, 2020).

Contemporary social medicine characteristically recognises that health phenomena intertwine with the context in which events take place, generating efforts to constitute a framework that strives to demystify the political, economic and cultural processes underlying the distribution of health and disease. Eric Carter, Associate Professor of Geography and Global Health at Macalester College, whose work is dedicated to a regional focus on Latin America, stated: "Social medicine's tendencies were always centrifugal, integrative, and anti-reductionist, expanding the boundaries of the study and practice of medicine to include the study of the political-economic and social structures that shaped life chances" (2019:800). Social medicine brings biomedical research closer to disciplines that comprehensively analyse society beyond epidemiological associations and biological mechanisms, seeking to more accurately depict the processes involved in population health (Metzl and Hansen, 2014; Westerhaus et al., 2015; Adams et al., 2019). The social sciences of health found in social medicine pursue this goal through anthropology, sociology, social history, humanities, and geography studies (Porter, 1997; Holmes et al., 2014; Westerhaus et al., 2015).

Though epidemiological evidence and biological explanations are fundamental approaches in the contemporary knowledge production of health (Russo and Williamson, 2007; Illari and Russo, 2014), twenty-first century social medicine in the Anglo-European world focuses on the need to revitalise the inevitable complexity of ‘the social’ in the study of health and disease. As a field of research, social medicine today does not primarily seek to establish causal associations in population metrics,

nor contribute laboratory evidence on molecular cascades to explain the natural history of diseases. Instead, the emphasis lies in the processes and forces that impact health. Social medicine understands 'the social' as a fundamental category that captures both the object of study and explanatory mechanisms in health and disease. As the disciplines vary, the approaches to understanding *the social* are also multiple. As Adams and colleagues highlight:

> *"Among the methods useful for this work are the techniques of participant observation (from Anthropology), grounded theory (from Sociology), postcolonial studies (from history), gender complexity (from Women and Gender Studies), community participatory research (from Public Health), social constructionism and actor-network theory (from STS), various narrative approaches to data collection (from Medical Humanities) and even an approach that contemplates how the social may need to exceed the human (in Anthropocene studies). While these approaches have similarities and differences, they all generate opportunities for moving beyond facile notions of the social." (2019:13)*

Various authors have mapped out the ways in which 'the social' is examined in contemporary social medicine, clarifying the domains the field of research operates in (Stonington and Holmes, 2006; Holmes et al., 2014; Oberlander et al., 2019a, b; Condrau, 2007). Taking a cue from the recently published *The Social Medicine Reader* (Oberlander et al., 2019a, b), areas considered by social medicine include the experiences of illnesses and the clinician-patient relationship (Kleinman, 1988; Fissel, 1991; Fadiman, 1998; Wildes, 2005; Bourgois et al., 2006), the ethics in healthcare and social justice in health (Kaufman, 2006; Venkatapuram, 2011; Preda and Voigt, 2015; Buchbinder et al., 2016; Camporesi, 2018; Wester et al., 2018), the contextualisation of the social determinants of health (Wailoo, 2001; Farmer et al., 2006; Stuckler and Basu, 2013; Ottersen et al., 2014; Bourgois et al., 2017; Vonk and Holmes, 2019), and healthcare politics and system reforms (Horden and Smith, 1997; Ong and Collier, 2004; Petryna, 2009; Oberlander, 2012; Geissler, 2015; Wailoo, 2016; Biruk, 2018). This thesis focuses on the 'culture and epistemology of medicine', a domain that critically analyses the status of knowledge in health, and examines the system of meaning that provides the content to contemporary health practices. It includes the social history of medicine, the process of professionalism in medical specialities, the problematisation of the abnormal and pathological, and the social impact of new regimes of knowledge-power (Jordanova, 1995; Condrau, 2001; Stonington and Ratanakul, 2006; Reubi, 2009b; Rose, 2007a, b; Higashi et al., 2013; Kaufman, 2015; Kelly and McGoey, 2018). The critical analysis of ALAMES, as a situated style of reasoning

social medicine, contributes to the problematisation of medical epistemologies through the lenses of the Latin-American experience.

This chapter explores the methodology applied in the study of Latin American social medicine which ALAMES represents. The research is situated within the field of social medicine as outlined above, with an outlook towards the multiple ways in which local epistemologies speak back to the central debates and discussions in global health. That is to say, this chapter (i) helps situate the study of Latin American social medicine thought style in the broader practices of contemporary social medicine, and (ii) enables the comprehension of how ALAMES contributes to the broader debates of global health and social medicine as it is currently re-imagined and re-constructed.

The study of Latin American Social Medicine demystifies the multiple ways in which the regional context, constituted by its history, location and social relations, imprints a particular position on the ALAMES collective and the distinctive ways that it reasons about health and disease. Contextualising the association's way of thinking uniquely reveals how situated processes that are socioeconomic, political and cultural in nature determine the foundational assumptions, the background knowledge, and the sense-making reasoning of the association. Based on the contextualised sense-making phenomena, ALAMES imagines, achieves, and reproduces an attitude, consciousness, and subjectivity which displays its subaltern and subordinated condition in the region's epistemic hierarchy. While the perspective emerges from the shared experiences embodied in the association's practices and outputs, the present doctoral study departs from generating a chronological account of the social medicine thought style. It does not aim to create a sequential scheme of facts about the history of ALAMES, nor seeks to characterise social medicine within the formal analysis of a grand theory of the field. Instead, the aim is to show how power asymmetries, systematic oppression, and structural injustices specific to Latin America in the twentieth-century shaped the organisation of social medicine and how it operates – all from the viewpoint of the actors themselves. Towards these ends, ethnomethodology is the primary approach applied to effectively capture the relationship between the context and the 'natural attitude' of Latin American social medicine way of thinking (Halkowski and Teas, 2010; Tolmie and Rouncefield, 2013; Trace, 2016).

Ethnomethodology (EM) mainly focuses on research from the bottom-up, analysing how personal experiences are made into 'objective reality' that is shared within a community through accountable

practices composing a corpus of thought (Lynch, 1993; Ten, 2004; Dowling, 2007). This method of research and analysis derives from the sociology of science and technology and empirically describes the social contingencies that bring a situated epistemology into performance. As an approach that makes explicit the molecular context in knowledge-production, EM unearths the local minutiae that establish day-to-day interactions and provides a gaze towards the ordinary events of everyday life that the thought style carries out. More specifically, EM seeks "(…) evidence in the talk or other actions for how the participants orient to and understand each other" (Halkowski and Teas, 2010:214). The approach understands that interactions occur in sequences and patterns, which can be dissected as utterance accomplishing a goal (Schegloff, 2007). EM assists in answering the question of how a way of thinking came to existence in the first place, that is, how a thought style was assembled into a 'social world' that manages an order, produces knowledge and maintains a sense of scientific validity. By taking the viewpoint of the actors as they interact with each other, EM brings together accounts of local knowledge and practices, emphasising the heuristic resources that the thought style provides to subaltern groups. Situated non-dominant epistemologies ultimately seek to empower, give a voice and enable self-representation of groups that are marginalised, forgotten or rendered invisible.

The structure of this chapter is as follows. Firstly, the methodology of the thesis is explored in three segments: 1) EM is outlined, examining the main characteristics of the approach and the opportunities the approach provides. The segment includes the exploration of fundamental concepts for EM, including the social world, ethnomethods, natural attitude, indexical expressions, stock of knowledge, amongst others. 2) A subsection dives into the limitations of the approach, beginning with the challenge of exploring a transnational association that has no central hub or work-setting from the viewpoint of EM which mainly explores sense-making from the indexical expressions of intersubjective encounters or interactions. And 3) an additional limitation of EM is outlined, specifically, the limited scope in the empirical data of the approach which, in the context of the present research, justifies the use of biographical accounts of ALAMES' members.

Secondly, the chapter expands on further resources utilised in the analysis of Latin American social medicine. On one side, the use of 'thought style' as the main category for this thesis is explained and justified. On another side, the process of data collection is outlined describing inclusion/exclusion criteria, my positionality in the association as a researcher, sources of data and

how access was achieved on practice, amongst others. Lastly, the structure of the thesis is further clarified, detailing the underlying themes connecting the thesis (capitalism as the central organising concept for ALAMES, and the association's political opposition to 'epistemic injustices') and the content per chapter. The chapter closes with final remarks that place the reader to encounter subsequent chapters.

II. ETHNOMETHODOLOGY AND BIOGRAPHICAL ACCOUNTS:

a) ETHNOMETHODOLOGY, THESIS AND OPPORTUNITIES:

EM was formalised by Harvard sociologist Harold Garfinkel in a break away from the formal analysis of traditional sociology, the latter mainly commanded by Parson's structural functionalism during the mid-1950s US (Emirbayer and Maynard, 2011:231 - coincidentally, Parson was Garfinkel's PhD supervisor at Harvard). EM differs from traditional sociology in that it insistently refocuses the research gaze towards the study of taken-for-granted language, actions, and resources that constitutes everyday interactions and create “accounts of formal structures” (Garfinkel and Sack, 1970:345; Montigny, 2017:333). The success of co-creating these structures through the dialectical process of engagement among parties is considered, by Garfinkel and colleagues, a practical 'accomplishment'. The ongoing success of the achievements depends on the parallel production of properties such as reproducibility, repetitiveness, uniformity of the practices, competence in the performance of the actions, accountability towards other members of the corpus, independence of the practices from particularised actions, amongst others (Trace, 2016). Parson's approach, in contrast, was taken to neglect the specific local and endogenous processes through which facts, meaning, and patterned everyday life is constituted. At the core of the dissent, therefore, EM challenges *a priori* statements about knowledge and epistemology brought about by universalist and generalising sciences that traditional sociology represented.

The value of EM rests in the detailed account of situated and embodied practices, focusing on the reasoning underlying the practices as these are performed in the concrete interaction of individuals.

The approach advises against deciding in advance the form and content of the 'formal structures' based on prior analytical studies, theoretical framework, grand-narrative or worldview which attempt to stand over and above experience (in a false sense of superiority). EM places the subjects enacting practices at the centre of research by examining the way that people, through their interactions, forge a 'social world' with its order, sense-making and knowledge production (Heritage, 1998; Harste and Mortensen, 2000). As highlighted by Hak (1995), EM does not examine the end-point object of a thought style and how it corresponds (or not) to some original design. Instead, the approach looks for the embodied work and how it produces the end-point object analysed (what this work consists of and how it was 'embodied').

In this way, the 'social world' that interactions create is always produced and never independent from the endogenous processes of encounters - making the incommensurable and ordinary mechanisms through which social order is crafted, also known as 'ethnomethods' (Leiter, 1980:5), the central object of research in EM. For Garfinkel, though actors in their everyday reasoning achieve a sense of the world as an 'objective reality,' this sense is made employing various 'procedures or methods' in coordinated networks. Reality is made "(…) not by way of a common system of symbols (i.e. by thinking alike), but by actively achieving a *sense* of knowing things in common and of having the 'same' perspective were they to change positions with one another" (Emirbayer and Maynard 2011:237). EM is consequently viewed as a social theory in its own right, heeding attention to how social order is made possible and performable in the agency of members, and contributing to the wave of constructivism which impacted the social sciences extensively from the second half of last century. The approach "(…) studies how a member's social world (a world comprised of everyday objects, action, and interaction) is constructed, accomplished, and maintained, and what this social reality looks like from the viewpoint of someone situated within it" (Trace, 2016:48).

At the core of the contingent 'social world' is the pragmatist realisation that practices and rationale of thought styles constitute social identities or subjectivities 'because of' and 'in order to' embody the habits the way of thinking generates (Emirbayer and Maynard, 2011:234). The roles that a given subject undertakes during their lifetime are not acquired in a process separated from or before the practical reality of actions and interactions of encounters that perform the thought style. Likewise, Garfinkel argued, the 'facticity' of the reality upon which a subject operates results from the actor's continuing work of interaction within the same epistemological coordinates. Although the social

world is co-created, the order proposed by a thought style rests on the assumptions that the 'objective reality' indeed exists as such and that it is external, material and transcendent in its properties.

As explored by different authors (Leiter, 1980; Heritage, 1996; Rawls, 1998), the common-sensical reasoning constructed in the 'social world' is based on ('ethno')methods that are shared among members of the situated epistemology. These ethnomethods, Garfinkel argued, develop into unreflective forms of action or a routine frame of mind that suspends critical doubts about the constructed reality and crafts an apparent sense of 'objective facts' – a phenomenon conceptualised as 'natural attitude' (Schutz, 1962, 1967 in Cuff et al., 2003). To give a sense that the social world is self-evident, factual, and real, 'natural attitude' captures the procedures of members that naturalise the social order into background reasoning, mostly lost from the reflective gaze of members and made implicit, habitual and taken-for-granted (Garfinkel, 1967:7). EM suggests that a particular thought style is essentially the result of integrated ethnomethods that assembles a way of thinking and acting which is assumed to be objective, accurate, and reliable. A way of thinking, moreover, which results in a bundle of outputs or 'indexical expressions' including knowledge-resources, ways of interpreting reality, sense-making of experiences and particular political objectives (Trace, 2016).

Following Schutz (1962), EM interprets the emergence of ethnomethods as drawing from a shared 'stock of knowledge' that provides the necessary components for a course of action in a given setting. As highlighted by Heritage, the 'stock of knowledge' refers to "(…) all kinds of *background* knowledge about people and circumstances that we employ and take account of in our dealings with others" (1998:180, italics are my own). The background knowledge, Heritage continues, are elements pragmatically constructed over time and used as points of reference to make sense of what people 'say and do' in any given social encounter. These elements include "recipes, rules of thumb, social types, maxims, and definitions…social types or idealisations of people, objects, and events" (Leiter, 1980:5) – also perceived as nudging, invitations, responses, speculations, pauses, perceptions, and other features which establish the conditions through which the social world is crafted. Additionally, Schutz argued that the stock of knowledge rests on the assumptions that people's experiences of reality are *reciprocal* between parties interacting (regardless of the standpoint each person inhabits) and that the differences in perspectives about reality are *congruent* enough to be inconsequential to the experiences of each person.

Conclusively, the concept of 'stock of knowledge' is both (i) background goods "coming from a person's own experience" or the biographical accounts of a life narrative integral to the culture and/or community, and (ii) the derivative substance of "learning and interacting with others," unique in its particular configuration at a given time and place, and built upon the assumptions of reciprocity and congruency (Trace, 2016:53). As shall be explored below, the fundamental features of EM associated with the background knowledge nudge at the limits of the approach as applied to investigate Latin American social medicine. As highlighted by Gurwitsch, the stock of knowledge "(…) forms the frame of reference, interpretation, and orientation for my life in the world of daily experience, for my dealing with things, coping with situations, coming to term with fellow human beings" (1979:119). In other words, the background knowledge is pivotal for the ethnomethodological approach as these elements constitute the pre-emptive core of ethnomethods. The concept and its links to ethnomethods, nevertheless, are often negotiated in the EM research to enable the analysis of the taken-for-granted elements of the thought style according to the empirical data gathered.

EM, therefore, studies social interactions to answer the questions: *what* parties are doing and saying, and *how* they make their interaction understandable – also described by Garfinkel as the 'just-thisness' of everyday life, in attempts to return to experience in scientific inquiry as lives *in situ*. The finely-grained analysis comes from the details of how speakers and practitioners organise their utterances and actions, making the scope of an EM research limited to the observable aspects of the encounters or the 'endogenous organisation of the interaction' (Halkowski and Tear, 2010:216; also in Maynard and Clayman, 1991). In a close examination of interactions, researchers have produced rich accounts of the progression, sequence, resources, and changes occurring as encounters develop. Research unearths fundamental elements of social relations in work settings including information asymmetries, injustices of various forms, power moves, resistance in the agency, rights and obligations for a response, and other social phenomena (see, for example, Gill, 1998; Maynard, 2003; Stivers, 2005). Hence, the social world created through the interaction comes by way of subjectivities being moulded within the reality of a particular setting.

A strength worth considering for the current research on Latin American social medicine is that EM supports the notion that the contingent 'social world' is visualised not merely through the practices

enacted in interactions, but also through the outputs which the thought style produces. These outputs include knowledge-resources like publications, public statements, briefings, conference proceedings, seminars, workshops, pedagogical resources, books, articles, and a multitude of archival information. For EM, the outputs "(…) do not provide adequate facts or sources of information about experience and behaviours of their creator" (Trace, 2016:55) – yet, they are indexical, reflexive, and accountable. That is to say, archival information and associated resources embody the taken-for-granted practices and rationale that EM seeks to unfolds in the study of everyday interactions, imbued with the stock of knowledge and natural attitude characteristic of Latin American social medicine. Consequently, archival and knowledge-resources can be considered intersubjective facts constructed collectively and perceived as independent from personal inclinations (Zimmerman, 1969; Meehan, 1986; Cicourel, 1995; Garfinkel and Bittner, 1999). Accountable objects of a social world, therefore, have a meaning for any member within the context of ALAMES and Latin American social medicine thought style.

b) LIMITATIONS OF THE APPROACH:

The clarification above is relevant given that ALAMES, as illustrated in the previous chapter, is a transnational organisation distributed across Latin America, with over twelve national chapter and five research nodes that extend past borders and languages. The largeness of the association poses exciting challenges at the level of research design. To bring together the multiple voices that arise across the region, the thesis could not focus on one location alone (whether research centre, public or private university, high-academic or healthcare institution, social movement or collective, etc.). The lack of physical positionality also explains the avoidance of participant-observation as the central approach to the thesis' methodology. To remain in one work-setting would not do justice to the complexity of the situated social medicine way of thinking. Instead, the research began from the particular social world which ALAMES, as a multi-sited collective, yields in the production of outputs (publications, books, seminars, etc.). This pragmatic decision contrasts classical EM research typically located in settings including healthcare institutions (Fisher and Todd, 1983; Heritage and Maynard, 2006; Gill et al., 2011), policy-makers office (Zimmerman, 1970; Heritage and Sefi, 1992; Heritage, 2002), laboratories of science (Lynch, 1985; Livingston, 1986), or astronomy planetariums (Garfinkel et al., 1981).

The restricted encounter with a specific institutional setting this research adopts challenges EM as traditionally presented by its pioneering authors (Sudnow, 1978, 2001; Lynch et al., 1983), and constitutes a first limitation of the approach. To be clear, the limitation is that EM centres around work-setting practices and interactions, creating a gap of opportunity to analyse thought styles which are not connected merely by institutional ties but rather articulate through academic networks, research nodes, and media outlets. In a time where life is portrayed online, and all features of thought collectives can be (and are) shared through the click of a mouse or pad, the restriction to one specific work-setting or institutions appears outdated and requires rethinking. This is the case of Latin American social medicine. The current research addresses EM's limitation by analysing ALAMES' indexical expressions in the form of knowledge-resources and epistemological outputs. Put differently, the doctoral thesis rests on the assumption driven by EM that sense-making methods and how they are deployed in action heavily rely on the 'ordinary, familiar, and unsurprising' that members draw from recorded information (Cuff et al., 2003:163). Therefore, output knowledge-resources from Latin American social medicine are evidence of the "(…) underlying patters of member's common knowledge and experience" (Garcia et al., 2006:399; also in Meehan, 1986:71).

The exploration of ALAMES archives to compensate the gap of opportunity presented by EM aligns with two fundamental features which the latter approach sponsors at the theoretical level: 'competence' as a vital membership principle of a thought style, and 'breaching experiments' that mark ethnomethods visible for research. Following the underlying thesis of EM, the natural attitude of ALAMES crafts a thought style that displays a particular world and order appearing to be ready-made and shared. Within this world, archives and associated knowledge-resources represent the accomplished 'facts' about reality, wielding highly specialised meanings. Though archives are available to any person taking part in the rationale and practices, the documents are fully eligible and understood only by members whose outlook in life is impacted by the thought style. Consequently, given that EM explores the ordinary and familiar ethnomethods in their taken-for-granted character, researchers are expected to engage with thoughts styles at an intimate and personal level.

On one side, the idea of 'competency' relates to the ordering capacity members have to know and apply the norms and rules of the thought style, their intimate connection with the stock of

knowledge, the underlying conditions that made it possible, amongst other features. Competency enables one to recognise and inform a situation as an actual subject of the thought style, to recreate and/or organise the normative social order that makes the practices of a thought style intelligible. In acquiring this feature as a researcher, the particularised ways in which Latin American social medicine, for instance, confers meaning to personal experiences and the surrounding world may be inferred and imported with accuracy. As stated by Emirbayer and Maynard (2011:237), any 'indexical expression' or knowledge-resource generated by the thought style makes sense only within the achieved setting upon which they are produced. Consequently, the norms and rules of an intelligible and orderly social world do not exist outside of the context where the common-sensical reasoning operates – nor outside of the member's practices that materialise the thought style within this context (Garfinkel, 2002).

In this way, methodologically, EM encourages an agenda of 'radical empiricism' (James, 2003 (1912); Garfinkel, 2005 (1948); Rorty, 1975) by nudging researchers into 'becoming' a competent member that enacts the practices and reasons the rationale like any other actor embedded in the thought style (see Mehan and Wood, 1975; Schwartz and Jacobs, 1979). As stated by Ten: "Garfinkel has suggested that to be able to study the specifics – the 'quiddity' or 'just whatness' – that make up a particular trade, an investigator should develop a rather deep competence in that trade" (2004:30). Becoming competent implies the full immersion into the particularised or situated work setting so that claims and statements one makes are taken seriously by practitioners of the thought style themselves (Garfinkel and Wieder, 1992; Pollner and Emerson, 2001). Dowling (2007) suggests that the distinctive feature that differentiates EM from other closely related qualitative methods, particularly ethnography, is precisely the movement beyond participant-observation and towards the incorporation of the thought style into one's ethos. The process of becoming competent, also termed 'unique adequacy' (Rawls, 1999; Garfinkel, 2002), is therefore fundamental to EM.

This thesis on Latin American social medicine is not focused on providing intellectualist orientations to the rationale and practices of ALAMES, nor attempts to judge their actions from the standpoint of independent analytical criteria. Instead of a third-person view that risks reproducing the imagined Global North-Global South divide, I set out to 'become' a member of ALAMES to produce a first-person outlook of the thought style. For this purpose, I began by taking the 2018 online introductory course on Latin American social medicine offered at the ALAMES web portal. The program consisted

of 10-week fortnightly module featuring central areas of concern for the thought collective, including the social basis of health phenomena, healthcare systems and reforms in Latin America, political action of the ALAMES *militancia*, gender asymmetries in health, food and environmental sovereignty, interculturality in health, amongst others. Each session provided literature and reference to prepare and featured ALAMES videos on the topic usually consisting of a discussion on the topic organised by two-three of the association's scholars. The lectures also required the completion of worksheets and pedagogical material that evaluated the content learned. On the day of the class, members met through an online video conference directed by ALAMES' general coordinators. They brought together other practitioners from the national chapters and research nodes whose expertise nurtured the virtual discussion. Interestingly, the course had no affiliation with any university, but was autonomous, ran independently, and offered a certificate upon completion.

Through the program, I managed to get involved in multiple forums and discussions, initiated separate focus groups, assisted and attended additional seminars organised by ALAMES, made close friends and established academic ties with numerous members. The goal was to fully position me within ALAMES to learn, understand and even defend the thought style against challenges often encountered. It was an attempt to gain full-membership not merely as a researcher, but driven by a personal conviction that certain features of Latin American social medicine are worth incorporating in my background knowledge, lexicon, and belief. I learned the details and nuances, gestures and actions, language and concepts indexical to the collective – with an eye out on the taken-for-granted features that had prominence, to describe and analyse how the ALAMES social world was assembled and gets achieved.

In practice, it was difficult to reconcile my clinical background with the situated epistemology as, more often than not, ALAMES members altogether rejected biomedical evidence despite the collective's prerogative against any exclusivism. More importantly, even though biomedical evidence still constitutes truth-claims of high validity, legitimacy, and authority; ALAMES still fabricated an arbitrary sense of antagonism against it. Put differently, the rejection of biomedicine by various members is a sharp contradiction to the foundational epistemological framework the association claims to follow as biological mechanisms and epidemiological evidence are part of the Social Determination model (see chapter four). It is worth noting that ALAMES 'exclusivism' was

mostly encountered during the XV International ALAMES Conference, rather than in the interviews, the introductory course, or the multiple events attended – which highlights the political character of the conference (rather than the academic focus of most western scholarly meetings). Nevertheless, the overwhelming feeling of the political rallying of troops at the conference made evident the challenges of negotiating access to empirical data and my professional convictions. Interestingly, I also faced mockery based on the fact that my research was based at King's College London – a UK institution that various ALAMES members considered part of the mainstream Anglo-European academia and, therefore, linked with the universalising science of traditional sociology or biomedical thinking (that disregards situated epistemologies from the 'Global South').

Image 2.1 ALAMES Argentina introductory course on Latin American Social Medicine 2016, Session 3 'Health Policy: Universal Healthcare Systems vs Insurance Companies.' On the picture, Dr. Mario Rovere (speaking), Dr. Giglio Prado (moderator). Universidad de Lanus, Argentina. Source: ALAMES Argentina, 2016.

On another side, 'breaching experiments' rests on the idea that active reasoning beyond the unreflective actions of a natural attitude emerges in situations where the regular conduct or the habits applied to a context no longer prove valid. In such moments, the taken-for-granted categories and notions that have previously gone unnoticed become central in the re-interpretation of common-sense, meaning and action. As EM explores the taken-for-granted methods of a thought style to derive the value-making of the collective, it is common to find strategies which attempt to

break the familiarity and ordinariness of practices and rationale. Such techniques are termed 'breaching experiments' (Garfinkel, 1967). The breaching experiments are intentional disruptions to the naturalised language and habits (ethnomethods) of a thought style which seek to create conflict among competent members. Critical to this notion is the belief that such instances of destabilisation suspend the regularity of the practices to enable analytical insights into the meaning, tensions and ruptures of the fundamental features of a collective sharing a social world. The inquiry consists, then, on remaining in the facts and experiences, yet critically examining the constructed reality and attending the perplexities disruptions create. That way, doubt on the implicit and accustomed aspects of the thought style enables conclusions that are closer and more meaningfully connected with the real practices of collective like ALAMES.

In disrupting habits, 'breaching experiments' demystify the processes through which members of a thought style seek to re-establish the social order or the ordinary formal structure of the practices. The processes display the system of definitions and re-definitions that competent members employ to arrive at new patterns of behaviour, modifying their subjectivity and making conduct a malleable object. The notion taps into conceptual connections that EM has with pragmatist such as George H. Mead (1964) in issues like the consciousness of the 'working self'. As Emirbayer and Maynard state: "For Mead, the 'working self' involved in the action is aware of originating that action but is otherwise engaged in it unreflectively. Its 'reflective attitude' only comes about when that action is blocked…" (2011:235). That is to say, the procedures or ethnomethods through which social order is accomplished can come under 'conscious reflective scrutiny' to researchers and actors themselves when these are obstructed or made futile (Garfinkel, 1963; 2002:211).

There are multiple ways through which authors in EM suggest 'breaching' the ethnomethods. In some instances, breaching experiments were achieved by examining real-life or 'natural' situations. For Garfinkel, the examination of real-life situations is, in itself, enough to destabilise assumptions in a particular social world when conditions enable the taken-for-granted features of a thought style to be exceptionally prominent. Such was the case of 'Agnes', the transgender woman in search of the gender-changing operation during the tumultuous sociopolitical milieu of the 1960s (Garfinkel, 1967). At other times, breaching was initiated by actively challenging or placing blockages to the rationale and practices of a thought style (Ten, 2004). This allows a real-time visualisation of the ways social order is re-established among competent members. In these cases, competent members

place themselves in extraordinary situations that contradict their sense-making. Situations include mastering difficult or unknowing tasks, or following instructions that fall outside of the accustomed epistemological coordinates of the thought style (see, for example, Wieder, 1974; Robillard, 1999).

In breaching the Latin American social medicine, careful considerations were made given that ALAMES does not account for practices within the traditional work-setting that EM favours. For the thought collective, the situatedness that gets work done systematically is not located in an institution but resides within a specific social standpoint. The ALAMES standpoint seeks to represent the oppressed, dominated, and forgotten viewpoints of gender asymmetries, labour exploitation, ethnic exclusion, and other injustices. The emancipatory position that Latin American social medicine claims operationalise a common-sensical set of rules and norms in case-by-case scenarios of their encounters and experiences. Most commonly, the standpoint occupies flexible yet very particular places of encounters like colloquiums, seminars, courses, workshops, conferences, organisational meetings or assemblies, or simply their direct interactions/conversations across many universities and research centres in Latin America. These also include digital means like videoconferences and pre-recorded videos mounted on social media platforms. It was by way of locating myself in these scenarios that the 'breaching experiments' were advanced. However, the endeavour implied a new set of skills previously not considered in the revision of the methodology.

Notably, the observation of ALAMES habitual affairs, expecting extraordinary situations to arise that may reveal the perplexities of the thought style could not be merely a passive endeavour as implied in the ‘natural’ breaching experiments. In the diversity of scenarios within which the collective mobilises, destabilisations of Latin American social medicine also had to be created or pursued, seeking to delve into sense-making activities that were taken-for-granted through what Ten labels a ‘strategic preference for the extraordinary’ (Ten, 2004:41). Optimal opportunities presented during the interview phase, for instance, whereby direct discussion enabled disparities, tensions and contradictions to emerge. During the conversations I had, originally scheduled to last 1.5 hours at most, different questions were posed that tackled specific terms or concepts that featured prominently in both archives and proceedings. The point was not to take these concepts or classifications for granted, but rather omit prior knowledge about them or cease common assumptions about the terms to enable the re-construction of sense-making by the interviewee. These responses could also be compared between ALAMES members at later points.

Beyond queries over definitions, the questions often turned into clear challenges to the ordinary course of thinking to 'breach' the thought style. Actors were asked to provide their views on terms such as militancy, capitalism, social determination, hegemony/counter-hegemony, indigeneity, right to health, subjectivity, amongst others. Interestingly, and crucial for the arguments in the chapters, many definitions differed – including the process through which the terms made sense or were central for the thought collective. When faced with alternative explanations from other members, actors tended to justify their points of view by referring directly to their life narratives, established new 'valid' statements based on past experiences. This brought into perspective the way ALAMES members transform their situated life narrative into 'objective facts' that gets documented as part of the epistemological outputs produced by Latin American social medicine. Scientific facts in ALAMES, though constructed through the mediation of social interactions, are upheld and maintained by the biographical character of the claims and statements. Sense-making emerges as a feature of past experiences and life stories – intimately related to the 'stock of knowledge' of ethnomethods.

To capture the 'natural' breaching experiments, this thesis also recorded, transcribed and examined systematically interviews, seminars and conference talks to unearth underlying principles and unnoticed gestures. In so doing, much of the empirical analysis relied heavily on language and statements beyond the indication made by EM's classical approach. The added technique utilised in the thesis comes closer to Conversational Analysis - a subfield of EM stemming from all the same theoretical presuppositions and developments (Atkinson and Heritage, 1984; Sacks, 1987, 1992; Jefferson, 1989; Schegloff, 1997, 2007). Taking language as another type of indexical expression, the main difference between the two approaches is that Conversational Analysis pays exceptionally close attention to details such as gestures, silences, accents, hesitations, and other resources during a discourse. Conversational analysis, moreover, is greatly assisted by voice and video recording to enhance the precision and range of information gathered – being more 'rigorous' in data collection (Ten, 2004:49; Dowling, 2007: 828). Though the analysis of Latin American social medicine did not involve such in-depth reasoning, the research enriched the conclusions through conversational analysis-like approach of conference proceedings, seminars, lectures, pre-recorded videos, etc.

c) THE CASE FOR BIOGRAPHICAL ACCOUNTS:

The intimate connection between the output of the thought style, as a site to locate the natural attitude of the collective, and the stock of knowledge is fundamental, and points to an additional limit of EM found through this research. For EM scholarship, ethnomethods are constituted by *background* or *stock* knowledge, which itself is 'transferred' to the individual through social arrangements including "child-rearing in the family, teaching in school, on the job-training and conversation among peers" (Cuff et al., 2003:156), alongside other features of socialisation in the life trajectory of a person. “This natural attitude,” Trace adds elsewhere, “is defined through people’s associated stock of knowledge at hand – knowledge that is accumulated throughout life and that is profoundly social in nature” (2016:58). According to Trace (2007, 2008), knowledge used to construct ethnomethods intertwines with the life course of the person and the constitutive experiences in their life trajectory. Though Trace focuses in early stages of life, such as the 'hidden' curriculum in schools, the argument underscores how situated experiences are transformed into objective realities in the achievements of thought styles according to EM. Trace concludes that ethnomethodological research 'encourages' scholars to take stock of knowledge not merely as a set of rules or resources to uncover, but as topics of study in their own right. Implicit in the statement is the apparent EM focus on embedded research, that is to say, the interest to unearth the biographical accounts or life narratives of competent members to address the underlying content that contributes to the natural attitude of a thought style.

Though EM conceptually addressed ‘stock of knowledge’ as a feature emerging from the biography of the person, the approach does not intentionally engage with the past experiences of competent members. Instead, EM solely addresses the material evidence observed at the moment of intersubjective encounters, including the actions, gestures, language, and other elements relevant to the context of the interactions. The limitation revolves around the *scope* of ethnomethodological research when addressing the multiple ways through which thought styles are assembled. While exponents of the approach nudge at in-depth analysis of features underlying the stock of knowledge, EM actually limits its gaze to the interaction itself. Following Montigny (2017), one apparent reason is that EM’s shrunken perceptibility enables the so-called ‘ethnomethodological indifference’ principle. On the issue, Garfinkel wrote:

"Ethnomethodological studies are not directed to formulating or arguing correctives…Although they are directed to the preparation of manuals on sociological methods, they are in no way supplements to 'standard' procedure, but are distinct from them. They do not formulate a remedy for practical actions, as if it was being found about practical actions that they were better or worse than they are usually cracked up to be. Nor are they in search of humanistic arguments, nor do they engage in or encourage permissive discussions of theory". (1967: viii)

In Garfinkel's original vision of EM, the approach to comprehend everyday life is not meant to radically transform the features that conduct, habits, and unreflective reasoning display. At the surface level, ethnomethodological indifference seems to justify a disregard for more in-depth inquiries on multi-layered aspects highlighted by scholars themselves, including the stock of knowledge and biographical accounts. Although much of 1970s sociological scholarship viewed EM as deviating away from grand-narratives and recuperating the centrality of experience, Garfinkel's agenda involved principles that scholars like Montigny found too compliant for meaningful research. Consequently, ethnomethodological indifference appears to avoid making attempts to "(…) modify, elaborate, detail, subdivide, explicate, or contribute to building a foundation for sociological reasoning" (Montigny, 2017:333). The 'indifference' principle guides EM towards general neglect for 'sociological reasoning' (Garfinkel and Sack, 1970:346), displaying an approach that is uninterested on the transformation or radical change of work-settings, institutions and societies.

Montigny clarified that, based on the development of EM in subsequent decades, ethnomethodological indifference actually meant the rejection of *apriori* diagnosis, classifications and course of actions. Garfinkel himself amended the confusion, explaining on his later work that the term essentially targets the traditional approaches in sociology at the time (indifference to Parson's functionalism), rather than aiming at sociology as a field itself (Garfinkel, 2002:171). Instead, Montigny continued, ethnomethodological scholars are driven to "(…) investigate, examine, and explicate the ways that people in the interactions of their daily lives recognise and make such matters accountable" (2017: 334) – providing opportunities for the approach to investigate biographical accounts that may help address pressing concerns of contemporary liberal societies. Furthermore, according to Watson, Garfinkel's program tackled the formation of accounts that accorded 'privilege' to its concepts and procedures while denying or 'downgrading' the accounts of alternative viewpoints (1998:202). The authority and validity of non-dominant accounts (ALAMES as a case on point), Watson added, is 'dis-preferred' as misconceived or deemed a 'false

consciousness' for relying on a scheme of knowledge different than the 'scientific' one. The basis of such down-grading or degradation is the preference towards formal analysis (i.e. traditional sociology) for categorising life based on seemly rigorous, logical and impartial criteria. Ethnomethodological indifference, therefore, restores fairness by identifying 'upgraded' epistemologies and heeding no attention to their baseless discrimination.

In exploring Latin American social medicine, I began with the presumption that the challenges of my life trajectory created hierarchies and standards from which I establish the value of conditions, persons, or situations presented my way. Often, the adherence to these models led to ruptures and tensions when encountering other viewpoints which do not follow the same coordinates as previously conceived. As a medical doctor, taught and trained in 'mainstream' biomedical thinking (private university with clinical work within urban areas), the encounter with and becoming of ALAMES social medicine was hard-pressed by demands to engage with extraordinary situations, unknown people, and radically different views on health and disease. Even in the understanding that one ought to experience everyday practices as these come, the constant tendency was to echo the texts, courses, guidelines, tests, training, and clinical settings I received in my clinical upbringing. Therefore, Garfinkel's 'just thisness' (2002:92) or the features which occur in the here-and-now of ALAMES was continuously compared, judged, and accepted/condemned based on clinical categories, hypothesis, diagnosis, knowledge, practices, etc. The adherence to the research and the empirical data slowly emerging in the doctoral research process led to the conviction that one must explore additional fundamental features of the thought style, as presented by competent members, to avoid the formal analysis of biomedicine.

Yet, as much as EM condemns the ‘down-grading’ of formal analysis, the approach heavily relies on a limited *scope* that renders some things invisible to advance its agenda. Already Hak highlighted the issue as a problem of ‘observability of the context' in ethnomethodological research (1995). At the procedural level, Hak argues that EM constructs knowledge of only that which it has admitted as part of its underlying thesis – that is to say, a rigorous analysis of foundational elements like common-sense, the taken-for-granted ethnomethods, and the 'obvious' practices of interactions. For EM, Hak continues, these elements constitute the 'context' of an engagement or encounter and are also considered 'achievements' of the social world in sight (also in Zimmerman and Pollner, 1970:94). In vivo practices of interactions create 'points of fact,' accepted 'schemes' and implicit

claims that enable understanding and inference of all indexical expressions as legitimate and/or valid within the context. Put differently, instead of considering additional elements of the background knowledge that makes ethnomethods possible (such as biographical accounts or life stories), the core purpose of ethnomethodological research is the study of ordinary affairs and everyday work that assembles the corpus of knowledge at a given time and space of interaction among competent members.

In the EM reduction of the 'context' to elements of interaction, the broader social structures that are historically constituted, multidimensional in character, and upon which members of society find themselves embedded are considered only if these are accounted for in the interaction and/or are consequential for the organisation of the encounter (Garfinkel and Sacks, 1970; Schegloff, 1987; Schegloff, 1992; Emirbayer and Maynard, 2011). Social structures of socioeconomic, political and cultural nature characteristic of the trajectory at the local level are not part of the empirical data considered by EM unless explicitly referenced during a social interaction or implicitly associated for the development of an encounter. Context refers instead to the "(…) rules, habits, methods of action, coordinations, forecasts, attitudes, plans, and design" (Emirbayer and Maynard, 2011:252) – and other gestural activities or participant's orientations involved in a studied engagement (also in Schegloff, 1996). Therefore, EM tends to produce knowledge that does not extend beyond the particularities of a situation being looked. It avoids the analysis of pre-conceived social criteria that make up the substance of ethnomethods unless explicitly stated otherwise (Psathas, 1977 in Dowling, 2007:827). Consequently, Hak concludes, the comprehension of a thought style is only 'worked out' at the end of interactions and practices, when the 'context' as conceived by EM has been revealed (Zimmerman and Pollner, 1970:95).

According to Hak, the methodical reason to restrict the description of the context is to 'avoid' imposing features to the data that are not part of the competent member's standpoint (1995:126). Among the many implications of the prerogative above, a prominent one is an acknowledgement by EM that features which matter for analysis are case-specific and unstable amidst the diversity of elements implicated during interactions. Details such as biographies, histories, structural forces, outputs, amongst others, may or may not be included depending on the contingencies of member's actions during the particular encounter being studied. To determine whether empirical data may be first-order or second-order evidence for EM researchers is mostly ambiguous, setting up great

confusion during the investigation. A confusion which develops on two fronts. On one side, it is unclear which criteria or by what rule one must utilise biographical accounts for ethnomethodological analysis. On another side, no practical guidance is given in the ethnomethodological literature for a systematic and reliable analysis of biographical accounts. Ethnomethodological publications never specify how one is to know, for instance, the broader socioeconomic, political or cultural context which life narratives or biographical accounts open up to, nor how to make sense of these themes in the way that participants make sense of them when being shared. Without a directive on 'how to be' situated in the same standpoint as the members of the thought style, Hak warns, the researcher's approach to the context can easily fall back to formal sociological analysis that EM advice against.

I encountered the confusions above during the research, often assuming the stance of judge over member's claims about reality based on Marx's historical materialism. Given that historical materialism is foundational to Latin American social medicine, and assuming I was situating myself in ALAMES' viewpoint, I found myself accepting, rejecting, explaining or correcting much of the members' discourse using contemporary literature on Marx's theory in an unrestrictive use of knowledge. To correct, ALAMES members redirected my attention during the interviews to the accounts of their lived experiences and life stories where a better apprehension about the context in their terms could be grasped. Indeed, I followed Zimmerman's point of orienting the research gaze on the direction pointed by the members during the interactions (1992). However, the new direction guided me beyond the setting of the encounters and towards their biographical accounts. Notice how the tendency to tailor ALAMES' approach to Marxist literature is very similar to following the design of biomedicine to compare and contrast Latin American social medicine. In this doctoral thesis, though EM recognises the complexity of a social world by highlighting a multitude of features attached to sense-making, the arbitrary ethnomethodological tendency to restrict the scope of research to encounters alone runs the risk of resorting back to the formal analysis meant to be rejected in the first place (Hak, 1995:122).

The challenge being developed here, therefore, is the difficulty of navigating empirical data using ethnomethodological work. If a particular expression or action is observable for the analyst as an explicit part of the interaction, then it belongs to the data examined for critical analysis. If it is not visible, it is left out. Yet, in leaving features out, no part of the interaction is rightly enhanced, but

rather core elements which enable the methods of social world composition are being actively and arbitrarily ignored. In exploring Latin American social medicine, abiding by EM implies ignoring the length and depth of details which biographical accounts provide, mainly, the social processes and power relations that determined the conditions upon which ALAMES social medicine was made possible. As Montigny elaborated based on writings from Dorothy Smith (1990a, b; 1999, 2005), social phenomena and life-course trajectories that make up the background knowledge of thought styles are "non-local determinations of locally historic or lived orderliness" (2017:343). The expression refers to the need to analyse a broader context. Instead of studying a sequential course of actions occurring during the interaction (as EM would have it), the 'context' should explore the historical instances where sense-making is constituted through the sociopolitical, economic and cultural processes. In this way, the fundamental insight brought to bear is that researchers must appreciate that 'just thisness' is articulated by experiences that precede practices themselves. These are experiences that biographical accounts reveal.

Therefore, any given 'here-and-now' requires to consider its articulation with an 'elsewhere' – at least in the case of ALAMES. "Practices in the present and at hand are imbued with orders and forms of the past," adds Montigny, "networks of social relations and formalised obligations, authorised forms of movement and action (the dance), and an impending and answerable future" (2017:341). The practices and sense-making of ALAMES are connected and realised through the complexities of extra-local social relations and past experiences. Hence, a scope of research which restricts its view to the interactions alone does not suffice for a collective like ALAMES whose constitution of social medicine is intimately intertwined with the collective history of Latin America in the twentieth-century. The accomplishment of Latin American social medicine, as a thought style, cannot ignore its dependence to the complex hermeneutics of the macro sociopolitical, economic and cultural context in the region.

The labour of research is, consequently, to explain how dimensions of different temporality are melded into the accountable practices of Latin American social medicine today. Any correct critical engagement with Latin American social medicine depends on the indexical understanding of the context of ALAMES, which involves the in-depth scrutiny of biographies of those involved in the production of output knowledge-resources. It is on the biographical approach that the current thesis leans on to compliment the endeavour of EM. Hence, the solution to the limitation brought about

by the restricted scope of EM is an act of identification – a detailed outline of the context as narrated by the biographical accounts of the thought collective, as guided by members themselves.

As will become evident in the progression of the thesis, for the case of Latin American social medicine, the stock of knowledge that constitutes the ethnomethods in the process of co-creating the social world emerges from the collective life narratives which overlap under a historical context that members of ALAMES factually share. That is to say, the sense of shared experiences is not merely achieved from the thought style members are embedded in, subsumed by, or stylised from to become a particular type of subjects. As rightly pointed by Schutz (1962), the biographical accounts of members constitute an essential aspect of the background knowledge that is utilised in the accomplishment of the common-sense reasoning that is Latin American social medicine.

In this way, the exceptional feature of ALAMES is that the thought style is imbued by the standpoint and the local context experienced by its members during the second half of the twentieth-century – a period of great violence characterised by the persecution, oppression, repression, and slaughter withstood mainly by scholars, activist and social leader of the left-wing tradition. ALAMES is a diversity of situated experiences and social processes of a particular history of Latin America which is transformed into 'objective facts', a specific social world that understands itself as emancipatory, counter-hegemonic, and revolutionary. Latin American social medicine constructs, justifies and maintains the concepts, explanations, principles, and political goals which this thesis unravels; grounded almost exclusively on the social trajectory of Latin America that is expressed in each personal experience. This unique feature became evident when every interview and the intimate conversation carried out with ALAMES members and scholars quickly became a life-story narrative in attempts to explain the underlying ideas and motivations. The claims to scientific facts grounded in past experiences extend to the point of overshadowing alternative validity processes commonly encountered in the literature such as the transformation of practices, consulting the consistency of the claim with common-sense models, or the rendering futile a habitual social order (Garfinkel, 1967; Emirbayer and Maynard, 2011; Cartwright, 2020).

III. RESOURCES OF THE DOCTORAL THESIS:

a) FROM FLECK'S THOUGHT STYLE TO HACKING'S STYLE OF REASONING:

The point that Hak made, which I follow through for this thesis, is that EM often misses out the full picture of the 'context' by maintaining the field of its gaze on one party involved in the interaction (mainly, the institutional party or expert practitioner). In the case of this research, unless the analysis also considered the biographical accounts of ALAMES members, the mere application of EM observability as indicated by pioneers would erroneously conclude that truth-claims and statements from Latin American social medicine were notoriously developed to fit Marx's theory. Though this tendency is partially true, the biographical accounts of competent members that draw a thorough picture of the 'context' beyond the elements being constituted at the moment of intersubjective exchange (and certainly beyond the recurrent use of Marxist concepts, categories, and explanations). Conclusively, the solution to the limited scope of EM is the introspection from another feature that appears in the approach's thesis but is subsequently relegated to the background: Life narratives are brought to the forefront by ALAMES members themselves and configures the 'pot' being shaped and presented in this thesis.

An additional feature which was considered in the development of the research was the main category utilised to capture the specific nature of the ALAMES collective and the historical development of Latin American social medicine. This thesis used the concept of 'thought styles' or styles of scientific reasoning in health. According to Strasser and de Chadarevian (2011), this category has been used productively under different names by authors such as Thomas Kuhn ('paradigms'), Jonathan Harwood ('national styles'), Alistair Crombie ('styles of thinking'), Gerald Holton ('themata'), John V. Pickstone ('ways of knowing'), Michel Foucault ('episteme'), Ian Hacking ('styles of reasoning'), and Ludwig Fleck (Denkstil). These analytical categories help to articulate the trajectory of collectives, capturing the changes and transformations based on their context and, therefore, complementing EM. In the case of Latin America, the category of 'thought style' unveils the rationale and practices of ALAMES, socially and historically determined as represented by the situated experiences and struggles of the collective health movement. Thought style captures the spirit of an epoch in the way it shapes the ethos and discourses of the subjects. It also embodies the rationale and practices that reveal the underlying milieu of oppression, injustices and violence characteristic of twentieth-century Latin America. Lastly, the category enables the analysis of how

the propositions made by the thought style were crafted over time to become the situated perspective that captures the sufferings of certain subjugated and subaltern groups as objective facts. In this way, thought styles present a unique critical reflection to the realities of marginalised and silenced collectives, seeking to bridge together EM and biographical accounts in ALAMES.

Ludwik Fleck first described the notion of thought style as the compilation of rationale and practices that shape the way individuals and groups come to think and act on a specific concern (Fleck, 1981; Lowy, 1988; Cohen and Schnelle, 1986). According to Fleck, the core elements of the thought style result from the specific trajectory of a context, revealing the contingencies and conditions that make the epistemology possible. The resulting knowledge-practices and outputs, therefore, are not mere facts about an object of study but constitute the particularised ways in which a thought collective knows reality – that is, according to its positioned perspective and constitutive history. Hence, all scientific knowledge is historically and socially constructed, artefacts forged by the conditions that emerge from the contingencies of social processes over time. In exploring the features, this category provides epistemic resources to flesh out the aspirations, commitments and demands of the thought collective. Fleck suggested that thought styles embodied the ethos and background assumptions of the context in which these are embedded, representing a specific set of beliefs, attitudes, ethical models and political ideologies. Also, considering that the creation of knowledge is a relational and interactive process, the study of thought styles requires the engagement with individuals or groups, and the suffering intended to be represented. According to Fleck, thought styles function and develop only through subjects that ascribe and assimilate the epistemology, enabling the fundamental features of the rationale and practices to materialise. Fleck referred to these entities as 'thought collective,' which ALAMES as an association represents.

Fleck's inquiries on thought styles primarily aimed at considering the mechanisms through which a particular statement of a thought style shifts in quality from hypothetical knowledge to a truth-claim. For Fleck, the development of scientific facts took place through the 'translation' of knowledge between thought collectives. He defined translation as simplifying statements until claims are seemingly stripped from opinion, values or biases associated with the social context or other contingencies. Fleck explained that knowledge first originated from an expert thought collective, whose rationale and practices displayed a very stylised, vague and unspecific content in the construction of concepts, definitions, models and frameworks. As the chaotic and immature

information was translated into other peripheral collectives, the claims progressively developed into formal, concise and schematic statements, following more simplified thought styles. Once it reached the everyday lexicon or common-sense, the quality of knowledge became unquestionable and autonomous. Fleck asserted that the epistemic authority of a thought style emerged from the expert to the quotidian movement in knowledge that provided an illusory sense of neutrality, objectivity and impartiality. Therefore, a scientific fact is a qualitative characteristic of knowledge that results from processes which seemly strip off the history, context and social embeddedness from statements as the content is reproduced among different individuals and groups. According to Fleck, reaching such status was the mechanism that granted knowledge the stability and the capacity to expand in society as truth-claims.

Ian Hacking nurtured the thought style debate by arguing that knowledge, though constructed over time and dependent on the contextual contingencies, is still grounded in material reality (1982, 1992, 2002). When researching thought styles creating knowledge, Hacking suggested one must consider the analytical distinction between the object of study, and the *idea* about the object of study. The former simply exists 'as it is,' while the latter was established precisely by a thought style, such that the social construction of knowledge did not pertain to the object, but the *idea* about the object. Hacking explains that thought styles or 'styles of reasoning' are defined not merely by the fundamental features that shaped how collectives came to know reality, but also by the epistemological success of their truth-claims or the capacity thought styles have to represent an object of study accurately.

Hacking was concerned with the way 'objectivity' arose as a guiding principle among scientific thought styles, and the way this objectivity judged the epistemological success of the knowledge produced – that is, categorising knowledge as either true or false. For this author, thought styles were neither inherently objective nor did they contain some essential features that made them neutral or impartial. Instead, 'objectivity' in a thought style derives from the rational and practices themselves, making the thought style its reference point to judge the knowledge it creates. Hacking's focus, as a result, did not lie on the actual truthfulness or falsehood of a statement, but on the elements within the thought style that rendered statements true or false against the benchmark of its principles. Consequently, thought styles functioned as epistemic resources to make claims, statements and propositions about reality perform as either true or false.

Despite the absolute terms used to judge epistemological success, Hacking emphasised the elements of a thought style as criteria that determined the quality of knowledge. The value of a truth-claims, Hacking added, was relative to – and derived from – the style of reasoning to which the scientific statement belonged. Hacking's social constructivism meant that a thought style was *positive*, insofar as it imputed epistemological importance to statements made, making them either truths or falsehoods relative to their own standards. In this way, the construction of a thought style is the aggregation of its own body of positive knowledge about reality that is then reproduced by a collective of experts. The relevance of Hacking's view of thought style is that any given shift from one style of reasoning to another implies an entirely different standpoint of positivity and, therefore, an entirely new body of knowledge. Thought styles are distinct between each other, not merely by their truth-claims or fundamental features, but by the truth-standards that judge the quality of their statements. Therefore, thought collectives do not necessarily have the same standards of judgement, as each may hold different *styles of reasoning* from which reality is known. These styles are incomparable and untranslatable, and cannot be engaged in debates of agreement or disagreement about truth. The relevance of incommensurability of thought styles for this thesis is that, although ALAMES is a non-dominant epistemology, the study of Latin American social medicine ought to be completed without the normative claims of universalising sciences.

For both Hacking and Fleck, a thought style emerged at a specific time and context because of a distinctive historical trajectory. The positivity of a thought style is also contingent on past incidents associated with it. These contingencies act as the scaffold from which the edifice of rationale and practices are constructed. Hacking captured the bundle of social, political, economic and cultural contingencies of history in the notion of 'matrix' (1999). The term referred to the unique historical setting within which the bundle of elements of a thought style emerged and flourished, and through which a thought style comes into performance. As Hacking stated:

> *"If positivity is consequent upon a style of reasoning, then a range of possibilities depends upon that style. There would not be possibilities, candidates for truth or falsehood, unless that style was in existence. The existence of the style arises from historical events…the fact that they (propositions about reality) are candidates for being true or false is a consequence of a historical event." (2002:167).*

Despite the centrality of historical incidents, Hacking argued that for thought styles to become epistemologically authoritative, they are required to reach independence from the historical contingencies that brought it into existence. If a thought style sought not to rely on externalities to prove itself valid, then it must turn upon itself to remove the traces of the externalities that made the thought style perform its positivity. According to Hacking, the method by which a style of reasoning reached this level of independence is 'self-authentication', to ratify its scientific knowledge by using self-fashioned criteria. Rather than 'translate' between collectives *à la Fleck*, Hacking's self-authentication is carried out through the aggregation of positive knowledge by the thought style itself. Self-authentication is, therefore, a circular process of proving its claims are true by applying its methods. As a result, the acquisition of authoritative epistemic status is a self-fulfilling prophecy for Hacking. A prominent example of self-authentication is the statistics paradigm that used its models to prove its claims as rational and scientific while claiming independence from history, context and externalities, statistics claiming truth without questioning the very basis from which the judgment was made (Hacking, 1990).

The uniqueness of applying EM and biographical accounts in the study of thought styles is that the mixture unearths the ways an epistemology is historically determined and connected with the culture. It also unveils the situatedness and non-dominant nature of the core elements by exploring the granularity and molecular features of the thought style. A critical analysis of ALAMES takes its lead from the narratives, arguments and biographies accounted for by the individuals and groups ascribing to Latin American social medicine. EM reveals that local collectives transform situated experiences into epistemological resources and knowledge to help oppressed and subjugated groups interpret reality, organise experiences, and propose courses of action (Trace, 2016). A situated epistemology empowers and supports self-determination by giving those involved meaning to themselves and others through the production of knowledge and epistemological frameworks that are based on the background assumptions of the context on which the thought style is built. EM and life stories, therefore, draw attention to the particular standpoint that underpins the collective's sense-making, which is used to make decisions and determine how to know the world.

b) THE COLLECTION OF DATA:

This thesis links the context of Latin America at a particular moment of its history to the biographical accounts of actors who currently perform as competent members that co-create the social world that is Latin American social medicine. For this purpose, a bundle of life stories from pioneers, leaders, prominent names and members of the association were brought together, converging around the question of Latin American social medicine as a thought style, as a life goal, and as a life choice. The scrutiny of life narratives revolved around themes of their life trajectory, such as how they were led towards ALAMES? Considering the underlying principles of the association, where does the inclination towards the thought collective emerge? What are the multiple experiences through which Latin American social medicine was made relevant to the ways they think and act upon health and disease? Amongst many others. Crafting a collective biography involved the following procedure:

Situatedness in ALAMES: As a junior doctor, I first encountered ALAMES during the 'right to health' movement in Colombia in 2013. The movement involved a bundle of strikes, public manifestations, picketing, occupying, social media involvement, amongst other actions, organised by professional grassroots organisations protesting against a new wave of neoliberal reforms on healthcare seeking to expand the privatisation of the national system and empowering further the fraudulent insurance scheme of Colombia. Since the implementation of the current national healthcare system in the early 1990s, the model has been fraught with numerous scandals of corruption, private corporatism, biomedical exclusivism, the ongoing management of financial collapses (the most recent in 2009), and its own version of 'judicialisation of health' or the involvement of legal courts to access medications and healthcare resources but without a state-wide mandate of 'right to health' in the Colombian constitution (until 2015). Throughout the decades, numerous reform bills have been passed in Congress attempting to remedy the weakness but without modifying the underlying for-profit policies upon which the system was built. As will be expanded in chapter six, the Colombian healthcare system essentially follows the general outline of the international neoliberal reforms, structural pluralism, and new public management in healthcare.

The deep unsatisfaction and frustration of both patients and professional organisations on the faults and flaws of the system developed into full demonstrations and movements, manifesting multiple times on the streets against worsening working conditions, the struggle to access interventions and the immense amount of public resources deviated to private pockets. The largest of these protests

formed in 2013 against yet another bill attempting to 'reform' the system during Santo's government. Despite the mounting voices joining together against the new 'smoke-screen,' very few healthcare professionals were able to articulate arguments that holistically considered the depth and length of the Colombian healthcare system, or could respond to challenges emerging from the opposing policy experts. Very few voices in Colombia spoke truth with direction and knowledge – and these few competent voices emerged mostly from the Colombian national chapter of ALAMES. For junior doctors, like myself, the association's arguments spoke wisdom. Naturally, local ALAMES scholars caught the attention of most local organisations. They swiftly became the leaders on the national negotiations, which eventually revoked the bill and advanced further changes that are still under implementation in 2020 (i.e. the approval of the first statutory law that proclaims health as a 'human right' in Colombian law system). Though I did not join ALAMES until the 2018 XV International Conference, I dedicated my academic journey to exploring Latin American social medicine through the lenses of this organisation.

I drew together from interviews, conference proceedings, seminars, focus groups, and publications/archives made by ALAMES members. The inclusion criteria consisted of (i) ALAMES members that are scholars, practitioners, or contributed to the establishment of the associations, or (ii) scholars linked to the association through the relevance of their publications and/or teachings in ALAMES syllabus and/or reference literature[2]. Considering the multitude of voices in ALAMES that fit the criteria above, a second filter was utilised with the following criterion: people whose contribution is pivotal in the development of the thought style, that is to say, scholars whose personal and professional trajectories are intertwined with ALAMES in ways that the mere mentioning of their names evoke the rationale and practices of Latin American social medicine in the association. To narrow down the actors into fitting the latter criterion, I heavily relied on the organisational structure of ALAMES, as shown in the previous chapter and explain bellow.

From the General Coordination of ALAMES, I followed the practitioners involved between the period of 2016-2018, including both the exiting steering committee and entering group of scholars. The members of these committees include Ana Lucia Casallas (Colombia), Mario Rovere (Argentina),

[2] Conversely, the exclusion criteria for the empirical data included (i) Latin American scholars with no association with ALAMES, despite publishing or teaching on related topics in global health and social medicine (i.e. various members of ABRASCO, who publish in influential social medicine journals such as *Saude em Debate*), and (ii) former members of ALAMES that no longer link or associate themselves with the thought collective.

Rafael Gonzales (Mexico), Eduardo Espinoza (El Salvador), Emira Imana (Bolivia), Beatriz Salgado (Chile), and Alicia Stolkiner (Argentina). Other prominent names were considered from the ALAMES National Chapters, each of which are known for being leaders or head organisers in opinion and decision-making processes of the chapter. Some of the names amongst this group include Mariluz Martin (Paraguay), Ricardo Santamaria (El Salvador), Jose Leon Uscategui (Venezuela), Howard Waitzkin (US), Luis Lazo (Peru), Giglio Pardo (Argentina), Sara Fernandez (Colombia), Antonio Valencia (Bolivia), Carolina Telteboin (Mexico), Mauricio Torres (Colombia), Claudia Naranjo (Colombia), and Nila Heredia (Bolivia).

From ALAMES Advisory Committee, I was able to connect with various members that have been fundamental pillars in the development of the association both from the epistemological front and also due to their political influence. Members of this group include Saul Franco (Colombia), Jaime Breilh (Ecuador), Oscar Feo (Venezuela), Olivia Lopez Olivares (Mexico), Asa Cristina Laurell (Mexico), Mario Hernandez (Colombia), and Debora Tajer (Argentina). Additional members inquired and/or investigated, pivotal in the establishment of ALAMES and the development of Latin American social medicine, include Maria Isabel Rodriguez (El Salvador), Miguel Marquez (Ecuador), Sergio Arouca (Brazil), Everardo Duarte-Nunes (Brazil), Susana Belmartino (Argentina), Catalina Eibenschutz (Mexico), Edmundo Granda (Ecuador), Emerson Merhy (Brazil), Sonia Fleury (Brazil), Jarnilson Silva-Paim (Argentina), and Mario Testa (Argentina).

Though membership was a fundamental condition to be included in the empirical data, specific chapters go beyond this inclusion criterion to implement some exceptions. Exceptions were accepted due to the undeniable influences these scholars have made to ALAMES, judged by the number of times their publications are referenced, their names are utilised in public discourses, and the link often created during interviews. Among this group of scholars, actors include Eduardo Menendez (Argentina), Rafael Bautista (Bolivia), Boaventura de Souza Santos (Portugal), David Choquehuanca (Bolivia), and Jorge Viaña (Bolivia). These names circulate the primary literature of ALAMES, commonly found in the references and texts shared in the association's website, publications, and course syllabus. Additionally, their conferences have been central in various ALAMES international meetings, making their contributions pivotal points of encounter for members of the association. Therefore, though not officially part of the thought collective, their thinking certainly shapes the common-sensical reasoning of ALAMES to this day.

Selecting themes: The semi-structured interviews, done in Spanish predominately, developed around three themes that were revised in each interviewee as part of the process of scrutiny. Firstly, interviewees were asked about the constitutive elements of Latin American social medicine as a thought style, the rationale and practices of ALAMES. These elements include foundational concepts, explanatory frameworks, objects of study, guiding principles, political objectives, practices of different sorts, amongst others. Secondly, the interview zoomed in on the thought collective itself, inquiring the programmes, institutions, and social movements where members work, collaborate, or were established during their professional trajectory. The premise underlying in-depth inquiry of institutional settings was the fact that ALAMES, as an association, claims to integrate and represent social groups of various backgrounds to give them a voice and empower their political goals. Implicit in these claims is the idea that engagement with groups, presumably with a different life form which does not entirely align with ALAMES, provides an ideal and natural process of 'breaching' whereby the taken-for-granted elements of the thought style emerge and are challenged. The potential clash of groups within ALAMES shows the tensions and ruptures of the thought style, which the thesis revises throughout the chapters. And thirdly, the interviews expand on the life stories and biographical accounts that members shared.

Interestingly, most of the life accounts originated from the actor's initiative as a result of 'breaching experiments' that suspended the obviousness of certain concepts, explanations, and arguments. The breach came by asking members to explain comments further, rephrase or redefine concepts, develop examples on abstract notions, justify the use of specific categories, reinterpret arguments in light of counterarguments, among other obstacles. In unfolding these challenges, competent members drew from their life stories to add weight, meaning, and validity to their original claims or to the emerging ideas that were being developed throughout the interview. As memory-telling became, in a progressive way, pivotal in fully understanding the Latin American social medicine as a thought style; the expectation of having a biographical account turned into the norm for interviews and various questions were formulated regularly for more information. Life narratives were encouraged and nurture with my own stories that took off from points in the discussion or moments in the story, enabling more openness and dialogue. The conversation actively excavated what seem buried in the past, to bring it to consciousness concerning the present rationale and practices of the thought style. The complete analysis of these interactions was also carried out after the

transcription and translation of the interviews, where the responses and conversations were revised based on the thesis, categories, notions and explanations from EM.

Analysis of the data: In carefully crafting the biographical accounts, it is worth noting the peculiarities of the process to fully understand the mechanisms through which life stories became sources of empirical data. Firstly, revision of life stories followed the process of 'telling', which consisted on proposing open questions that nudged towards the 'broader' context and guided the conversation on how these connected to their way of thinking and then to the thought style. Questions were framed around what, how and why certain sociopolitical, economic and cultural elements that the members referenced were connected to Latin American social medicine. The responses to these questions, which followed language and expressions used by the interviewee, led to new memories that were followed to the culmination of the general idea. Many of the stories evoked anger, pain, sadness, wonder, etc.

Secondly, the interviews were recorded upon prior consent, transcribed and analysed using specialised software NVIVO12. As a memory-writing exercise, the richness of the accounts began to flourish further when additional information linked to the events being retold was revised. For instance, when Espinosa referred to Monseñor Romero and Liberation Theology, his experiences acquired different importance once the full story of the priest and the catholic movement was explored further. From being a side comment in the progress of his account, the encounter between Espinosa and Romero became central in realising the overlap between social medicine and the local persecution of left-wing groups. Similarly, Laurell's *Halconazo*, Franco's closeness with Hector Abad Gomez, Menendez's death-threats from the *Concentracion Nationalista Universitaria*, amongst many others, followed this 'enrichment' of information. Readers will notice additional information utilised in the thesis under the form of footnotes. The additional content, nevertheless, was not part of the empirical data. Instead, it was secondary knowledge that assisted in situating myself within the relevance of the events being described by ALAMES members.

Interestingly, when reading and analysing the stories, it is evident the overlap and constant reference to the same type of sociopolitical, economic and cultural challenges that determined their lived experiences, despite the differences on the form and content the context took. All experiences are framed in terms of struggles, resistance and resilience based on a narrative of repression,

persecution, exile, threats, precarity, oppression, injustices, and violence. Accounts often elicited moments of fear, anxiety, frustration, uncertainty, confusion, amongst others. Pivotal moments of Latin American history were recurrent, including the wave of military coups and dictatorships in countries such as Argentina, Ecuador, Brazil, El Salvador, etc.; alongside broader international interventions such as the articulation of dictatorships by the US-backed policies of *Plan Condor*, foreign funding for programs that openly worked against left-wing political thinking, and the involvement of international organisations in significant reforms of the region (including neoliberal structural reforms of the 80s-90s). The lasting connections that these social phenomena had with the situated experiences and memories of ALAMES members explain how embodied thinking shape the underlying truth-claims of individuals which aggregate together to co-create the rationale and practices of Latin American social medicine as a social world.

The overall picture of the region emerging in this research resulted from the aggregation of accounts from ALAMES, being that the context overlaps throughout life stories. The collective history constructed was written in light of the conflating discussions integrated from each competent member approached. That is to say, biographical accounts were not merely 'autobiographical' but were the means through which the social processes of twentieth-century Latin America are made visible within the rationale and practices of social medicine. The collective narrative is not about 'individual identities' but rather constitutes an 'invisible thread' in which ALAMES shows how it is formed and becomes constitutive of other subjects (Bronwyn and Gannon, 2006:11). In exploring the association through the member's account, their similarities and differences become open to interrogation.

Consequently, the deconstructing exercise of analysing biographies has the potential of transforming the thought style and, simultaneously, the way of being and doing within the social world. Collective biographies are acts of turning to ourselves to apprehend how individuals embody social forces of context-bound historical phenomena. It is a gaze towards Latin American social medicine to reflexively remember moments of production to reconsider the (re)constitution of the rationale and practices.

The application of EM and complementary biographical studies on Latin American social medicine also drew from a wealth of additional empirical data emerging from various sources. On one side,

the ALAMES official website (http://www.alames.org/) offered a range of digitalised documents that include press releases, published books, public statements, minutes of conferences, meetings and recordings. The website is also a source of the association's debates and discussions about the systematic oppression, marginalisation and structural injustices that fall upon non-dominant epistemologies in their subordinated and subjugated standpoint.

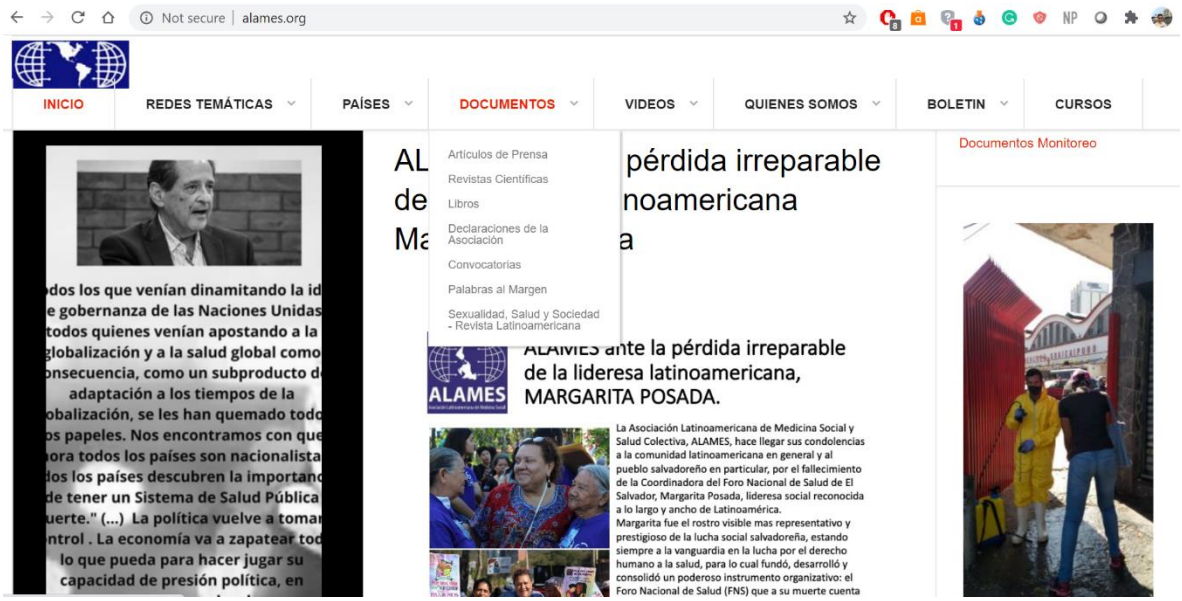

Image 2.2 ALAMES website last updated in June, 2020. The tab 'Documents' lists the resources available, including press release, books, public statements, etc. The first entry on the website honours the memory of Margarita Posada, health activist from El Salvador and ALAMES member.

Another source of data is drawn from a variety of journal articles published from the 1970s to the present, representing the scholarly work and underlying epistemology advanced by ALAMES. Because the papers and publications do not explicitly reveal the author's affiliation to ALAMES, the literature was sorted by the writer's relationship to the association, and the journal of publication. The most relevant used by the collective included *Social Medicine*, an academic and open-access journal by the Department of Family and Social Medicine at the Albert Einstein College of Medicine in NYC; *Saude em Debate*, published by the Brazilian Centre for Health Studies (CEBES); *Saude Publica*, a journal that unites various universities in Brazil; and numerous others from Latin America, such as Cuadernos Politicos, Cuadernos Medicos Sociales, and Ciência & Saúde Coletiva. Additional ALAMES material was also found in international journals such as *Social Science and Medicine*, *International Journal of Epidemiology*, *The Lancet, The American Journal of Public Health,* and the

Pan-American Journal of Public Health. Various research sites were also used to draw on the academic literature, including the Social Medicine Portal (http://www.socialmedicine.org/), the social science journal catalogue from the Brazilian Virtual Health Library (http://revistasp.bvs.br/), and the Pan-American Health Organization database (http://www.paho.org/hq/).

Lastly, fieldwork was in the form of active engagement at the XV International ALAMES Conference organised in La Paz, Bolivia in October 2018 – which I attended. The conference was titled *Saber y poder popular en la conquista del derecho a la salud y la vida: La Transformacion social para vivir Bien* (Popular Knowledge and Power in the Conquest of the Right to Health and Life: The Social Transformation towards Living Well) and was separated into three themes: (i) social movements and popular power in health, (ii) the deconstruction of Universal Healthcare Systems, and (iii) the new form of capital exploitation and its impacts on health. I also joined the pre-conference sessions organised by the Red Latinoamericana de Organizaciones y Movimientos Sociales por el Derecho a la Salud (RED- LOMSODES or the Latin American Network of Social Movements and Organization for the Right to Health), a recently-established node of ALAMES that gathers health organisations across the continent who are focused on the struggle for the Human Right to Health. Leading up to the events, I also joined various WhatsApp groups, and social media pages which offered insights into political ideologies, newsfeeds and debates on the most pressing issues across Latin America. All the empirical material was coded and organised through the NVIVO12 software.

Image 2.3 Group photo at the XV International ALAMES Conference celebrated at La Paz, Bolivia. October 2018.

c) STRUCTURE OF THE THESIS:

ALAMES rationale, practices and ethical commitments that rekindled the foundational social medicine principles will be explored throughout the thesis, particularly those features associated with local social movements, the struggles against capitalism and the opposition to epistemic injustices. Latin American social medicine is based on the affirmation and reiteration that the relationship between society and health is complex and dynamic - requiring the integration of multiple epistemological perspectives to comprehend the nature of population health better. To address Latin American social medicine as a thought style, this thesis is structured as follows:

The third chapter and first empirical segment of the thesis advances a critical analysis of the ALAMES historical trajectory from the biographical accounts of the collective health members. The research

unveils the social medicine militancy characteristic of the collective health movement in light of the socioeconomic and political turmoil of twentieth-century Latin America. In essence, the second half of the last century in the region was characteristic of state violence, persecution, stigmatisation, repression and slaughter of socialist/communist leaders and academics. These leaders advocated for a radical transformation of the underlying structures of society in favour of equality, justice and solidarity – placing themselves in direct opposition to the authoritarian regimes of the time. The violence against left-wing partisans impacted the ALAMES collective in two ways. Firstly, the armed repression and political silencing of authoritarian states repressed the action of the social movements and populist strikes articulated with ALAMES. Secondly, political persecution also consisted of the direct attack to social medicine members, leading to the massive exile of intellectuals. The impact of this context upon social medicine crafted a particular type of persona within the collective deemed necessary to effectively act upon the immediate context of totalitarian regimes, systematic injustices and institutional oppression.

As explored in chapter three, the endeavour to construct the anti-capitalist, anti-imperialist, anti-American and emancipatory persona above, took ALAMES on a journey to change [FS16] health epistemology towards a more critical approach: the Marx's historical materialism and critical theory. The chapter explores the constitution of the ALAMES militant based on the integration of historical materialism and the imagined reality of Latin America at the time. The reader will notice a series of tension and ruptures through the contextualisation of the ALAMES narrative by way of intersecting the personal struggles of the actors, their militancy and the incorporations of the critical social sciences in health. Notably, the ALAMES collective focuses on the critique to the developmental policies of the 1960s Latin America (also known as *Desarrollismo*), the resulting public health and preventive medicine reforms within the healthcare sector, and the behavioural approaches at the core of capitalism in health.

The second empirical chapter of the thesis (chapter four) explores the epistemological basis of the social medicine thought style by considering the challenges to the so-called *Hegemonic Medical Model* and its connection with the ALAMES constructed idea of capitalism. Beyond the socioeconomic model which capitalism represents, the ALAMES collective uses the term 'capitalism' as the way contemporary liberal societies interpret the relationship between health and society. Mainly, capitalist medicine is the de-contextual, static and ahistorical bundle of risk factors

otherwise made into measurable variables that fragment reality into actionable pieces. The social medicine collective argues that the hegemonic capitalist model in health ignores the underlying social processes making the conditions of unequal population health possible, and creates a viewpoint towards the social determinants of health that fails to integrate the real complexities of the context.

In contrast, the chapter revises the ALAMES 'counter-hegemonic' response to the capitalist model known as the Social Determination model. The model is a type of situated framework in health that serves to disclose the core features of a social system for normative judgement. It also organises the way ALAMES health epistemology comprehensively thinks about the relationship between health and society. The chapter delves deeper into the theme of 'epistemic injustice' to clarify how Latin American social medicine thinks about its epistemology in light of the dominant biomedicine, and the potential transformation of health epistemology to construct an inclusive 'ecology of knowledges'. The reader will also notice an emphasis on the ALAMES application of historical materialism in health through the use of various concepts inspired by critical theory including subsumption, dialectic movement, social reproduction, and levels of determination. Interestingly, though social epidemiology in the US has vast diversity, much of which overlaps with ALAMES work on the Social Determination model (i.e. Nancy Krieger's Ecosocial Theory), the collective consistently considers European-American contributions mainly part of the *Hegemonic Medical Model* – and, therefore, antagonistic to Latin American social medicine.

Additionally, it is worth highlighting that these first two empirical chapters primarily devote to the in-depth description of ALAMES' fundamental narrative and epistemological basis. That is to say, the analysis largely assumes a high degree of homogeneity among the collective as though it is a unified body. The purpose of this presentation is merely to display the complexities, language, and epistemology of ALAMES in precise ways. The homogeneity, nevertheless, is apparent as the collective wields considerable differences and contestations that shape the thought style. Though chapter three and four explore various tensions and ruptures, the next two chapters delve into the actual heterogeneity of the collective and how the clashes among competent members reconstructed new forms of Latin American social medicine sense-making, knowledge-production and social world altogether.

The third empirical chapter or chapter five examines Latin America's experience with interculturality in health. This topic is an ongoing conversation between social medicine and the region's Indigenous worldview, otherwise known as *Sumak Kawsay, Buen Vivir,* or Living-Well. Sumak Kawsay is characterised by a strong sense of community and harmony with nature, distinctively treating nature as a subject of rights, and constructing knowledge based on environmental sustainability. Amidst the exponential growth of extractivist economies in Latin America, *Buen Vivir* takes particular precedence for the social medicine collective because, over recent decades, Indigenous movements have mobilised massively to protest against the destruction of land and dispossession of their territories sponsored by neoliberal policies. This uprising has created a renewed spirit of emancipation in Latin America, posing various challenges to the collective health movement.

The *pueblos originarios* (or 'original' Indigenous Communities) have prompted social medicine to reinterpret Latin American history, not from the development of twentieth-century capitalism, but starting with sixteenth-century colonialism and western modernity. The challenges forced ALAMES to re-evaluate basic premises of social medicine thought style, including the origins of capitalism, the problem of western exceptionalism, the conceptualisation of the Latin American political subject, and the emancipatory agenda in population health. For ALAMES, the real impact of interculturality in health is reflected in the re-definition of capitalism as a 'civilising project' that captures the foundational principles and ethos of contemporary societies, and the reconstruction of health epistemology that integrates local perspective and situated knowledge.

The final empirical chapter of the thesis explores the healthcare system according to ALAMES, and its connection to the 'right to health'. ALAMES takes the view that neoliberal healthcare reforms, known as *Cobertura Universal de la Salud* (Universal Healthcare Coverage or CUS), has co-opted the 'right to health' to enable market principles to enter healthcare, consequently narrowing the definition of health as purely a matter of accessing services, pharmaceuticals and technologies. Also termed 'the pharmaceuticalization of public health,' the collective contrasts the capitalist view with the Brazilian *Sanitarismo* movement that defined the right to health as 'access to a comprehensive healthcare system' known as the *Sistema Unico de Salud* (Unified Healthcare System or SUS).

During the late 1990s, following the demise of the Soviet bloc and the weakening of left-wing politics worldwide, social medicine integrated the 'rights' language to advocate for the implementation of

the SUS in the region. The ALAMES' right to health' as the access to the SUS corresponds to an institutional strategy that both (i) guarantees the provision of services, and (ii) sponsors the so-called 'democratisation of health'. This democratisation involves action on social determination processes by incorporating social movements and local collectives in the healthcare system's decision-making spheres. The SUS also guarantees universal coverage for the population by citizenship, access to necessary services and technologies (irrespective of income), the full public funding of accessed services without added financial obstacles (co-payments, premiums or deductions), and total protection against economic catastrophe due to the exponential increase in healthcare costs.

Throughout the chapters, this thesis seeks to present a comprehensive and critical analysis of Latin American social medicine as a type of local knowledge and situated epistemology. The research revealed how the core features of the ALAMES became operational, and how rational practices formed part of a narrative that is critical of capitalism, imperialism and colonialism. ALAMES is relevant as it develops a local approach to social medicine that speaks to dominant health research, and constructs a health epistemology that connects with grassroots initiatives for the emancipatory transformation of contemporary societies. The primary collective's objective is to lead societies towards a more comprehensive understanding of the social basis of health and disease, by integrating the historical perspective of local contexts flagged by social struggles and situated experiences.

A biographical history of ALAMES offers a rich understanding of the epistemic injustices underlying the dominance of biomedicine in Latin America. It helps to explain the epistemological framework of Latin American social medicine, and how social movements were integrated into a situated way of reasoning health and disease, as well as providing a critical perspective of the Right to Health beyond the individual's claims to services, medications and technology. As the conclusion of the thesis highlight, this analysis is highly relevant in the current COVID-19 crisis and life after that. The pandemic has revealed the complexity of population health in ways that reductionist biomedical approaches are unable to respond. Latin American societies have echoed the rest of the world in systematically applying top-down measures to contain the virulence of the disease, including lockdown policies, the abrupt closure of borders, and public shaming of defaulters. However, the pressing difficulty to square public health measures with the social, political and economic realities of countries has turned the attention of multiple sectors to challenge the dominant health

epistemology and redefine the disciplinary and political boundaries of population health in western liberal societies. ALAMES provides significant insights to contribute to the construction of solutions.

IV. CONCLUSION:

This chapter explored the methodology of the thesis and additional epistemological and pragmatic resources utilised for the research. The objective of the research is a critical analysis of the situated epistemology of ALAMES by both (i) destabilising the core elements in search of ruptures and tensions and (ii) contextualising the local narratives through the exploration of situated experiences, positioned struggles, and collective sufferings of the ALAMES members in twentieth-century Latin America. EM links the thought style with the contingencies of the context, assuming the granularity of the context as the source of the situated epistemology. EM demystifies the systematic oppression, structural injustices and power asymmetries characteristic of marginalised and non-dominant epistemologies, and captures the multiple ways in which the experiences are transformed into objective facts that permeates the construction of the thought style of ALAMES. Fundamental concepts of EM were explored, including the 'social world', ethnomethods, natural attitude, indexical expressions, and stock of knowledge.

Additionally, the limitations of EM were also explored, narrowing down essentially two issues which were encountered and tackled in the development of the doctoral research. On one side, EM primarily positions the researcher in a specific work-setting that binds the empirical data to a particular time and space (i.e. primary-care within hospitals, judicial processes at national courts, or scientific evidence-making in specialised locations). Given the multiplicity of sites where ALAMES operates, including online domains, the thesis resolved the difficulty by heavily relying on indexical expressions or outputs knowledge-resources of Latin American social medicine thought style – capturing the diversity of voices as they are embodied 'naturally' in their work. On another side, the approach focuses extensively and thoroughly on the constitution of sense-making or 'social world' through the indexical expressions of intersubjective encounters. In so doing, EM restricts the *scope* of empirical data mainly to interactions and reduces the idea of the 'context' to the elements of an engagement which assist in creating meaning and sense of interactions. EM disregards broader

contextual analysis of socioeconomic, political and cultural processes which shape the biographical accounts and, consequently, determine the stock knowledge constitutive of ethnomethods. Hence, this thesis integrates the study of biographical accounts as presented by ALAMES members in the interviews, conference proceedings, etc.

Lastly, the notion of 'thought style' is also explained and justified. The concept enhances the concreteness of the research, simplifies the core elements of the ALAMES collective, and helps to understand how the social trajectory of Latin America is embodied in the lives of leaders and representatives in Latin American social medicine. The chapter also delves into the details of situatedness, collection of data and the structure of the thesis. These resources mainly point at the criteria in the selection of empirical data from ALAMES, the access to the data as experiences in practices and the multiple ways in which the challenges outlined above shaped the progression of analysis. My own position as a medical doctor encountering situated epistemologies on social medicine also revealed tensions and contradictions with the core features of ALAMES. The integration of biographical accounts proved pivotal in the development of the research, as the empirical chapters of the thesis will unfold.

CHAPTER 3

THE COLLECTIVE BIOGRAPHY OF ALAMES

I. INTRODUCTION:

"What the social struggles and militant movements in health throughout history have in common, particularly the groups in the decades of the '60s, '70s and early '80s, was the realisation that their immediate circumstances resulted from the vicious capitalist pressures…very similar to the conditions I experienced and regardless of where the person is coming from, every member of ALAMES also concludes that the fundamental problem determining the health inequities of our time is class structure and the imperialist manifestation of class in terms of exploitation, oppression, extraction of resources, etc."

- **Howard Waitzkin, Professor Emeritus of Sociology at the University of New Mexico and ALAMES long-time honorary member. Interview conducted in October 2018 at Café Ciudad, La Paz Bolivia.**

ALAMES is an intellectual movement grounded in grassroots initiatives that combines values, principles, and objectives that presents Latin American social medicine as exemplary subversive. Jaime Breilh, Ecuadorian medical doctor, professor of Epidemiology at the public *Universidad Andina Simon Bolivar* in Ecuador and ALAMES founding member; stated: "Being in the subordinated world of the south, the academic endeavour of Latin American social medicine has always been linked to the movements of social and political struggle since early in the emergence of collective health." As a renowned social medicine scholar in the region, Breilh's historical account of the collective health movement offers an anchor to understand the situated epistemology of ALAMES.

Breilh often refers to the collective health thought style as 'revolutionary', 'emancipatory', 'meta-critical', and 'counter-hegemonic' relative to the dominant capitalist model (Breilh, 2003a, 2010c,

2013b, 2020; Feo et al., 2012). For him, the wave of market reforms in the region during the second half of the last century established a new economic regime that deepened the extractivist industry, and expanded consumerism under false promises of 'development' and 'growth'. Indeed, for a short period after the Second World War, countries in Latin America withstood outstanding financial progress as a result of capitalist policies. However, the growing economy came at the cost of living and working conditions for most of the population that was already vulnerable to labour exploitation, institutional oppression, transnational monopolies and the co-optation of land by the historical impact feudal lordships.

Breilh explained that the second half of the twentieth-century Latin America was characteristic for state violence, a rising oligarchy, and the establishment of market principles. As a response, the 1960s and 1970s Latin America experienced a wave of popular movements that sought to vindicate the right to self-governance against the forces of the wealthy and powerful class. Social medicine thought style emerged on the foundation of this context, "(…) always grounded in the struggles of our people to overcome the social regime centred on the accumulation of wealth" (Breilh, 2003c in Morales and Eslava, 2014:24). This is known as the ALAMES *militancia* (militancy in Spanish) – a type of grassroots struggle which Breilh experienced first-hand. In fact, the struggles of marginalised groups were the same personal experience that many social medicine scholars endured during this time of socio-political turmoil. Various members of the collective health movement were threatened, tortured, kidnapped and sent to concentration camps as part of the repression against left-wing leaders. Consequently, ALAMES often presents local capitalism as the socioeconomic model determining the ominous, unjust, unequal and cruel context that crafted a world of authoritarianism, discrimination, and oppression.

The distinctiveness of the collective resides in the underlying *militancia* that emerged as a response to the persecution, stigmatisation, repression, violence and forced-exile inflicted by the right-wing dictatorships in the region. A militancy which, according to Waitzkin above (2018a), has crafted a profound sense of mutual support and camaraderie within the collective that remains to this day. Throughout the latter half of last century, when leaders' lives were at stake in one country, ALAMES members elsewhere provided refuge, work and some financial stability to secure the wellbeing of their colleagues. Hugo Mercer, Argentinian sociologist and founding scholar of the Social Medicine postgraduate degrees at UAM-X, explained that the response of the collective health movement to

the chaotic times proved their great capacity to not only produce academic output but also defend foundational principles like solidarity and reciprocity (2015).

The objective of claiming direct links with social struggles during dictatorial times reflects the social medicine aspiration to take up the cause of marginalised groups and represent an emancipatory identity against an imperialist agenda. For Breilh, Latin American social medicine "(…) cannot be anything but radically emancipatory" (2018a). This maxim has reinforced upon ALAMES a model of principles, obligations and practices to accomplish the revolutionary goals of radical societal transformation. The self-fashioning of ALAMES used Latin America's anti-capitalist history to infiltrate deep into the fundamental fibres of its militancy fabric, building on the idea of becoming an *organic intellectual*, and constituting a type of social medicine *persona* deemed necessary to act on a world of violent capitalism. To maintain this strong sense of militancy, social medicine took up the discourse believed to be the most effective to resist the North American market logic: Marxist historical materialism. The thrust of Marxism in health within ALAMES was also nurtured by the idea that social theory in health at the time did not provide adequate resources for emancipation, but rather reproduced the oppressive living and working conditions.

Rather than tracing the linear development of collective health in the twentieth-century, this chapter seeks to reconstruct the collective biography of ALAMES as told by the actors themselves. Individual and discontinuous life-stories from the collective health movement are aggregated to connect the context with the ALAMES thought style, and understand the way personal experiences became objective facts that shape the common-sense of the movement. As will be explored, these biographies result from a series of common incidents and situated contingencies typical of the Latin American context. The purpose of exploring these collective biographies is to critically analyse Latin American history as re-constructed by social medicine, focusing on the intersection between social struggles, militancy and the incorporation of the critical social sciences into health research. Thus, the main objective of the chapter is not to make value judgments on the thought collective, nor to question its coherency. Instead, the presentation of the collective health thought style in ALAMES as revolutionary, emancipatory, and counter-hegemonic is destabilised.

The chapter is divided into two sections. The first will disclose the context of oligarchy, military dictatorship, subordination to the US and inequalities that justified the necessity of the ALAMES

persona. The critical element of many of these biographies is the idea of militancy emerging from movements, protests, and armies throughout the trajectory of Latin American social medicine; to confront the region's immediate reality and sustain the type of critical analysis crafted within the collective. In addition, the ALAMES militant revolves around political practices of a dual nature. On one side, social medicine sides with grassroots initiatives and social movements that seek to act on the conditions of life and health. On the other, collective health strengthens the struggles and claims of movements through the epistemological development of tools and resources that help with the heuristics of social struggles.

The second section focuses on the distinctiveness of the social medicine ethos, which pertains to the integration of a critical social science perspective that is able to interpret, organise and make sense of Latin America's capitalist reality. The argument explores the ALAMES critique of traditional public health on the continent, also termed *preventivismo,* elaborating on the need to create an anti-American, anti-capitalist and anti-biomedical way of thinking. ALAMES incorporates more critical social science in health, which unveils particular tensions sustained in the social medicine collective to this day. Mainly, the collective health movement seems to contradict itself by reproaching the same international organisations and policies that enabled the constitution of the social medicine in the first place. The tension, lastly, is resolved through the biographies of ALAMES members.

II. LATIN AMERICAN SOCIAL MEDICINE MILITANCY:

a) THE 'SANITARY REALITY' OF 1970s LATIN AMERICA:

"(…) Latin American social medicine was a response to the Salud Publica Desarrollista. The critique was against Desarrollismo – the idea that economic growth would automatically lead to the betterment of health conditions. However, this idea of development…produced rural and urban misery in the region. Throughout the '70s, reality showed that there was a real setback in the living and working conditions. Setbacks which were expressed, for example, in the rise of infant mortality"

Laurell, 2011a.

Asa Cristina Laurell is a founding member of ALAMES, involved in the Health Ministry of the Mexican Lopez-Obrador government until recently. She is considered one of the most pivotal scholars in the emergence and consolidation of social medicine in Latin America, with a prolific journey into social medicine militancy since early in her academic years. She graduated from Lund University medical school in Sweden, and completed a Master's in Public Health from the University of California, before settling in Mexico in the early 1970s.

Deeply moved by the massacres of popular demonstrations, particularly *the Halconazo* in 1971[3], Laurell joined the May 68-inspired student uprising against Luis Echeverria's repressive dictatorship. Laurell helped to establish the magazine *Punto Critico* (Critical Point), a left-wing journal dedicated to political analysis of Latin America through advocating a socialist revolution. At the journal, she met and built a close relationship with the journal's chief editor and socialist leader Raul Alvarez, contributing to his independent communist party's struggle for democratic rights. A strong Marxist influence framed Laurell's perspective early on, determining the path of her scholarly work. As she stated: "(…) we had a pronounced opportunity to incorporate Marxist historical materialism in the analysis of health because, during this epoch, Marxism was the dominant social theory of all Latin American academia" (Laurell, 2013).

Shortly after, Juan César García entered the collective health scene, recruiting scholars from academia and Latin American movements to integrate the social medicine network (an essential precursor, as mentioned in previous chapters, of what would become ALAMES in the 1980s). Laurell vigorously participated in García's efforts by joining the team of scholars that created the Master's in Social Medicine at UAM-X in 1975, working alongside leaders like Hugo Mercer, Catalina Eibenschutz, and Jose Carlos Escudero. Though widely known for theorising the 'health and disease process' (Laurell, 1975; 1978; 1982), Laurell's *militancia* was notable for its close involvement with the mining and textile unions in Mexico during the 1980s. She stated that the early development of

[3] *El Halconazo,* also known as The Corpus Christi Massacre, was a covert operation in Mexico perpetrated by the government-trained paramilitary group identified by the name *'Los Halcones'* or The Hawks during the so-called Mexican Dirty War. The operation consisted of infiltrating student movements organised for the 10th of June 1971, the day of the Corpus Christi festival (a Roman Catholic liturgy of great national importance), to repress the strikes and attack members across Mexico City. Originally, *Los Halcones* was a group formed by military troops and young men recruited from marginalised neighbourhoods, trained in arms and personal defence by the government to protect strategic institutions targeted by local protesters. The paramilitary organisation soon grew into a secret force of the Luis Echeverria regime, used to confront, kidnap, torture, and eliminate the 'enemies of the capitalist state.'.

the ALAMES social medicine followed the vindication of basic needs sought by populist movements across Latin America (Laurell, 2017a). Given the syndicalist rebellion during the military and political dismantling of socialist movements in Mexico at the height of the Cold War, it was natural for academics at public universities like UAM-X to support social struggles. After all, "(…) public universities were part of the revolutionary movement" (Laurell, 2013). Her efforts developed into applying of the Italian workers model in the context of Mexico, in what came to be known as the *Modelo Obrero Mexicano* (Mexican Worker's Model, Laurell, 1984; Laurell and Noriega, 1988; Yanes et al., 1993). Laurell documented the research as part of her doctoral degree in sociology, concluding her thesis in 1986, and developing a book on the topic in 1989.

For Laurell (1989:1184), the social medicine collective began from constructing the 'sanitary reality' of 1960s-1970s Latin America that explained the conditions of life and health identified by social movements. The Latin American context in the second half of the last century resulted from the wave of policy reforms known as *Desarrollismo,* or Developmental policies, promoted by international organisations like the United Nations Economic Commission for Latin America and the Caribbean (CEPAL). The birth of the collective health movement connected with the opposition to developmental policies "(…) whose rhetoric focused efforts wholly towards economic growth, claiming it would naturally result in better population health by improving social conditions" (Laurell, 2017b). She asserted that *Desarrollismo* neglected actions on what is today conceptualised as 'the social determinants of health', under the assumption that market expansion naturally satisfied the conditions for optimal population health.

The theory sustaining *Desarrollismo* consisted of an economic order required to sustain financial growth worldwide. The structural organisation of the financial model reproduced a divide between core-industrial countries and the periphery-agricultural countries. However, the model also disproportionately concentrated a small share of global wealth to peripheral countries, by way of asymmetries in the exchange benefits. For Laurell, the structural injustices of *Desarrollismo* increased the gap of inequalities between the two types of economies, further complicating the fulfilment of basic needs, and the claims of self-governance in populations of developing regions. The disadvantageous conditions forged by the structural divide enabled the dependency of peripheral economies on the core countries, prompting developing nations to deepen their reliance on the massive extraction and exploitation of resources like oil, mining and land consumption.

According to Gonzales (2018b), former ALAMES general coordinator and professor of social medicine at UAM-X, US development rhetoric in the 1960s boosted international commerce to provide unequal benefits to the nations, based on the principles of 'comparative advantages'. This principle sustained that countries tend to specialise in the production of goods that are acquired cheaper, faster and more efficiently than other countries in the market - yielding large profits that enable them to remain internationally competitive. In the case of Latin America, these goods included natural resources, cheap labour and agriculture (see also Laurell, 1975).

Gonzales explained that Latin American countries devoted their exclusive focus on these industries, worsening their pre-existing vulnerabilities that came secondary to unstable governments, poor education and health systems, as well as a lack of technology for industrialisation experienced during the post-Independence period of the nineteenth century. Rather than achieving a 'core status' in the market hierarchy, the region plunged into an unrestricted economic dynamic with the incursion of multinational corporations to the region, and the drastic widening of foreign debt in failed attempts to industrialise the economy. Laurell added that, to sustain the 'Americanised lifestyle', the developed world exploited the assets Latin America offered, transforming the region into the 'backyard of the US,' dependent on the affairs of northern countries. Abuse and manipulation were justified locally by the capitalist aspirations to develop, as long as the countries 'followed in the footsteps' of western modernity, which the US embodied.

Breilh believed the state of economic dependency sponsored by *Desarrollismo* ensured gains that primarily benefited the already-strong local political sectors at the expense of the broader population's needs. Rather than achieving the betterment of living and working conditions, the imposed economic order increased social inequities and deeply worsened power asymmetries within and between countries. "Towards the '50s and '60s," Breilh explained, "monopoly capitalism caused a crisis in employment…where informal labour grew beyond the limits traditionally seen, hoarding a mass of underpaid labourers that multiplied in the following decades" (2003a:140). Breilh argued that *Desarrollismo* crafted a society of disempowerment that was progressively forced to endure the systematic labour exploitation and class oppression perpetrated by the emerging national bourgeoisie. As a result, throughout the '70s and '80s, Laurell and colleagues at UAM-X dedicated efforts to documenting the health effects of the capitalist crisis that resulted from the application of developmental policies (1975, 1982, 1989 see also Duarte-Nunes, 1986, 1987, 1991;

Ruffino and Pereira, 1981; Vasquez, 1984; Sepulveda, 1987). Though ALAMES recognised the high economic growth that followed *Desarrollismo*, "(…) these were also the years of being unable to break loose from the relationship of dependence with the great world powers" (Gonzales, 2018b). According to Gonzales, the identity of 'periphery' was so ingrained in the Latin American ethos, that to navigate outside the political coordinates of market logic required not merely a democratic clash of ideologies, but also the complete rupture away from the status quo. Gonzales added:

> *"Desarrollismo established the class structure that currently reigns the Latin American idiosyncrasy. A large proportion of the population remained with no public services, functioning as a permanent reserve army accumulating in the cities. Meanwhile, rural areas grew in misery with little or no possibilities to step out of these circumstances" (2018b).*

The notable rhetoric based on 'class struggle' that the ALAMES members expressed, denotes the inclination of social medicine towards Marxist critical theory, and unveils the modes of resistance in Latin America social medicine. As Laurell explained, the collective health thought style integrated historical materialism for its productive critique of capitalism. This was effectively used to interpret the Latin American context, giving meaning to the experiences of social struggles, and proposing political actions to transform societies. "We could not call it communism though," Laurell commented. "We used 'critical theory' instead to make the ideas sound better, and to make sure no-one got offended by our approach" (2017b). The academic sphere in 1970s Latin America, Laurell expanded, continuously struggled against the socio-political ambivalence of a US-inherited MacCarthyist rhetoric, and the shy attempts of some governments to apply necessary 'welfarist' policies. The shifts between the sheer support of – and bland opposition to – left-wing politics in the region made research by Latin American social medicine suspicious to many who recognised the influence of historical materialism in the research.

Nevertheless, the framing of reality in terms of class struggle and populist demands served to introduce the impending need for the redemptive, liberating or emancipatory work of social medicine 'militante'. To be clear, ALAMES militancy is conceptualised as the fundamental political practice of the collective of a dual character. On one hand, it refers to the close articulation of traditional and belligerent social movements that ground all rationale and practices in the social struggles of the local population. On the other, it is the social medicine collective's construction of

a situated epistemological toolbox to strengthen, help and contribute to the completion of emancipatory goals.

As Gonzales explained (2018b), responding to the cruel consequences of the growing market world, Latin America's population lived the disenchantment of false promises of desarrollismo, and revolted in popular protest against the incursion of 'greedy capitalism.' A multitude of social leaders aggregated angry mobs across the region in search of satisfying essential conditions of life, including affordable housing, access to public services, social security nets, fair pay, and protection against hazards in the workplace. On the rural front, people rose up against the disproportionate accumulation of wealth by traditional feudal families, known to have gained possession over land and commerce by partnering with political elites and oligarchic powers.

Bolivia's colonial heritage, for instance, upheld the ownership of primary natural resources in the hands of a few European-descendent families, eventually leading to the 1952 movement known as the *Movimiento Nacional Revolucionario*. Following Dr. Nila Heredia (2011a, b), former ALAMES General Coordinator and Health Minister of the Evo Morales government, the Bolivian revolution temporarily turned the tide of oppression by achieving a series of transformations, including the nationalisation of the mining industry, the closure of military institutions, the restriction and regulation of political power, and significant agrarian reforms. In other countries, dim opportunities and the pressing misery of rural areas created by the oligarchic state forced a mass migration of people to cities, who clustered in newly-constructed slums and marginalised neighbourhoods. The urban-industrial complex, Gonzales added, took advantage of the migrants' impoverished conditions, securing an exploited labour market, and the restriction of unionist activities. The context also provoked widespread riots and protest against institutionalised injustices. As a result, mid-twentieth century Latin America witnessed the rise of 'traditional militancy' in the form of workers, agrarians, students and populist strikes, which mostly took place peacefully at strategic points throughout the main cities.

Though the account of social movements in Latin America extends beyond this thesis, it suffices to note that the ALAMES narrative pinpoints attempts to decimate public demonstrations by way of US-supported state repression, persecution and massacres. Facing the severe violence of capitalist governments, Gonzales highlighted that various movements soon moved away from democratic

expressions and ‘took arms’ to craft a new form of militancy: the *guerrilleros* of the National Liberation Armies. The next section explores the belligerent militancy through the lives of Dr. Eduardo Espinoza and Dr. Nila Heredia.

b) THE BELLIGERANT MILITANCY OF GUERRILLEROS:

I met Eduardo Espinoza at Café Ciudad coffeehouse after the closing of the XV ALAMES International Conference in La Paz, Bolivia. The coffee shop, spacious and staffed with men in suits, was a discreet yet amenable place to talk in the old touristy town of Bolivia's capital city. The place was clearly a well-regarded middle/high class spot, which interestingly had no Indigenous clients accessing services, even though this demographic constitutes the majority of the population and was granted equality of status as a constitutional right through the Aboriginal president, Evo Morales. An ALAMES member explained to me: "The Indigenous won constitutional rights you see, but that is only a first step". An unspoken rule of discrimination apparently persists in exclusive areas of the city.

Dr. Eduardo Espinoza, is a political activist, former Health Minister of the last socialist government in El Salvador, and is currently ALAMES’ General Coordinator. During our conversation, he described the experiences of his 15-plus years in the *Frente Farabundo Martí de Liberación Nacional* (FMLN or National Liberation Front Farabundo Marti), the leading armed force in El Salvador's 30-year conflict. Espinoza is a very articulate, approachable, and warm middle-aged man. His wool poncho stamped with tribal patterns suggests an attempt to maintain the roots of his own commitment to the Indigenous population, despite his political role. The former minister is not the defiant image often portrayed in pictures of *guerrilleros*. He even described his involvement in the conflict as an ‘extraordinary’ phase of his life.

Image 3.1 2018-2020 ALAMES General Coordination. From left to right Dr. Beatriz Salgado (Chile), Dr. Alicia Stolkiner (Argentina), Lic. Emira Imaña (Bolivia), Dr. Eduardo Espinoza (El Salvador), and Dr. Mario Rovere (former ALAMES coordinator 2016-2018, Argentina). Photo taken during the election of new coordination at the General Assembly, XV ALAMES International Conference at La Paz, Bolivia. October, 2018.

Espinoza was born to a working-class family in a peripheral town in El Salvador, close to the port on the east side of the country that borders between Honduras and Nicaragua. Though he always studied at public institutions, the activist had no political involvement in socialist affairs until he took up medicine at Universidad de El Salvador. “Entering the university was a life-changing experience,” Espinoza explained, “it presented an environment of intense political effervescence…the institution offered a parallel education through a myriad of student movements, and political activism.” An involvement in grassroots initiatives introduced Espinoza to a different type of previously ignored history, consisting of the repression of unionist parties, the popular aspirations of communities, and the perpetuity of state violence. He explained that, throughout the ‘60s, it was common to encounter military raids on the university as part of the political agenda by conservative sectors in power against socialist leaders. Staff members were persecuted, intimidated, kidnapped, and sometimes murdered, in an environment of impunity and oppression. After a short period of peace

during the appointment of Fabio Castillo as university Chancellor, the conflict at public universities heightened in the early 1970s with the arrival of General Fidel Sanchez Hernandez's military regime.

Espinoza's own militancy began with cautious support for the student protests against abuses by the Sanchez administration. "Several times," he said, "we were pursued by the military, and managed to escape. Nothing bad happened, but it was sufficient to intimidate us. So, I remained mainly in my studies" (2018a). For Espinoza, clinical medicine did not imply any form of political practice in the manner advanced by popular strikes and public manifestations. The need was consistently to 'do much more', yet the fear was sufficient to keep him devoted to medical practice. However, medicine was never just a clinical matter in the context of Latin American public universities.

Shortly after entering medical school, Espinoza was voted to lead the Student Council, and began a life of political activism. This period coincided with the 1969 so-called *Guerra del Futbol* (Football War) between El Salvador and Honduras. The war was a three-day conflict between the two neighbouring countries, associated with the qualifying matches for the 1970 Mexico FIFA World Cup. El Salvador beat Honduras, and won a place at the international event. The defeat, nevertheless, sparked riots and attacks by Honduran farmers on El Salvador's military troops that had invaded the land near the border. Espinoza observed: "I went to the Honduras border as a volunteer…the Salvadorian army slaughtered the Honduran farmers and the people did not even know why! It was difficult to watch" (2018a). With his new political role, Espinoza's indignation turned into a fully-organised Council rejection of the military action by Sanchez, accusing it of 'furthering the financial interests of the oligarchy and ruling elite'. According to Espinoza, the US government used regional conflict to dissipate revolutionary attempts in El Salvador by diverting the people's attention from their deplorable living conditions to the violence perpetrated by a 'foreign' nation.

Espinoza suggested that the particularity of medical practices in Latin America was not the training experience itself, but the increased exposure to the dire circumstances of vulnerable population and the heightened inequalities caused by the discriminatory system. In the context of public universities, where most ALAMES members trained, medical doctors were expected to fulfil care duties in rural areas where conflict and misery were at their highest. "From Day One," commented another ALAMES member who asked to remain anonymous, "professors at the universities

continuously stressed that the state was paying our education with tax money, and that our duty was to pay back the efforts by serving the community." Similar to other social medicine members, Espinoza argued that the strong sense of social responsibility from public education and the direct experiences of the regional socio-political turmoil prompted some sense militancy in the medical doctor.

The 1970s in El Salvador was a time of constant upheaval, with many armed groups emerging and various student movements joining the ranks of alternative national-populist organisations. The Cuban Revolution, in particular, pressured the left-wing political sectors of El Salvador to act. Espinoza explained that the passiveness of communist parties left a crude sensation of 'abandonment and impotence' on the suffering population, prompting the establishment of the first armed forces in the country. These organisations grew exponentially in a short period, instigating the armed liberation of El Salvador from the oppressive national and international elites. According to Espinoza, belligerent groups aggregated into one unified front, known as the FMLN. "Everybody documents the Salvadoran Civil War as commencing in 1981 after the assassination of Monseñor Romero[4]," he said, "but the war actually started with the rise and consolidation of *guerrilleros* during the previous decade" (2018a).

The *guerrilleros* became a complex network of armed resistance that protected protests and movements when faced with military repression. They led the population to view the organisation as the only group that could protect them against the vicious and violent dictatorships. Though the increased clashes between groups lured Espinoza into the conflict, the activist was dedicated mostly to political discussions and clinical work away from the armed conflict. However, Espinoza explained:

> *"In 1975…while working at a health centre, a student march protesting against the military intervention of public universities advanced next to the clinic…as the crowd was approaching, we saw the military emerging from across the bridge…When they arrived, all troops came out of the trucks*

[4] Monseñor Oscar Arnulfo Romero was a Salvadoran Catholic archbishop assassinated by the National Guard under the orders of military and government officials. He was leader and well-known political activist associated with the so-called Liberation Theology, a strand of Catholic doctrine born in Latin America and adamant in teaching that the Christian Gospel consisted of favouring the poor and protecting the vulnerable population. Romero was known for making public the myriad of violations to Human Rights and manifested solidarity towards the victims of state violence. Romero has been canonised by the Catholic Church, recognised as a martyr in the persecution of faith, and stands as a representative of social struggles in Latin America.

and began shooting at the protesters. The streets were flooded with the wounded and dead. Some of the students ran to the clinic, looking for refuge. We covered them with patients' uniforms or disguised them as medical doctors because everyone thought the army was going to go after them..." (2018a).

Up until this stage of the conflict, Espinoza randomly supported the struggles by teaching *guerrilla* groups first-aid practices that were useful in combat. "The situation always moved me…People were fighting for scraps during harvesting season," he recalls, "living in crowded camps, and even relieving themselves in plain sight. It was awful" (2018a). Though the panorama of society was daunting, the turning point that prompted Espinoza's militancy was witnessing the massacre of students he mentioned above (perpetrated on 30th July, 1975 by the right-wing government of General Arturo Armando Molina). The life-changing experience, a slaughter that 'no-one ever gave an account of', prompted Espinoza to request his official incorporation in the FMLN as a *guerrillero*. For him, the significance of the belligerent militancy for the future of social medicine in the region resided in the fact that the armed groups did not conceive the struggle without full support of the broader population. The most important contributing factor in the effectiveness of the clandestine life and emancipation was, therefore, the articulation with people on the ground.

At the FMLN, Espinoza fought side-by-side with multiple marginalised sectors and abandoned communities who were organised into battalions on the outskirts of cities. Details of his life and experiences during the war, including military strategies, living conditions and combats against the army can be found in his autobiography, *Relatos de la Guerra* (Stories of War-Times, Espinoza, 2007).

Image 3.2. Eduardo Espinoza a.k.a 'Felipe Dubon' was captured by the military in 1985, enduring tortures and threat at the Mariona Prison. In a stealth move, the FMLN kidnapped the president's daughter and organised an exchange for Espinoza and other comrades (during the Jose Duarte administration). In the photo, Espinoza is warmly received by his FMLN colleagues after the exchanged. Source: Oña, 2008.

Like Espinoza, Dr Nila Heredia, general surgeon and former ALAMES general coordinator, believed a central feature the *guerrillero* militancy brought to the core of the collective health movement was its indispensable closeness with social struggles and grassroots initiatives. Following the National Revolutionary Movement in Bolivia, the volatile political arena faced the military coup of General Rene Barrientos in 1964. According to Heredia, an active militant of the Bolivian National Liberation Army, the violent regime run by Barrientos consisted of the swift implementation of *Desarrollismo* policies, significant setbacks to the progressive reforms achieved, the prohibition of all labour unions and socialist/communist parties, and the legal persecution of old revolutionary movements and syndicate leaders.

Amidst the repression, and after the success of the Cuban Revolution, the physician Ernesto "Che" Guevara arrived in Bolivia in 1966, aspiring to set-up the Bolivian National Liberation Army and to

overthrow the standing government. “El Che taught us that the revolution had to be done radically or not done at all," said Heredia (2016). Che and his Liberation Army recruited a wide range of members, beyond the traditional Marxists' orthodox parties, including students, university staff, school teachers, miners, industry workers, farmers, and even the rebellious branches of the Catholic-Christian groups. Heredia argued that in doing so, the armed resistance grounded all rationale and practices in the struggles and claims of the population suffering systematic oppression in Bolivian. The Bolivian Liberation Army "was directed by the Marxist ideology…but was made up of many sectors of society under the conviction that the revolutionary changes could only be achieved through the shared efforts of laypeople in society" (Heredia, 2016).

Following the Barrientos authoritarian reforms, the working conditions for physicians in the field progressively worsened to the point of ‘being unable to perform adequately’. Employment volatility, stagnation of salaries, and prolonged working hours coupled with the proliferating poverty and the systematic racism against Heredia’s Indigenous heritage and lured the physician to join the Revolutionary Worker’s Party of Bolivia that would soon adhere to Che’s army. Heredia joined the armed revolutionary efforts in the early 1970s, continuing with the Trotskyist political group and an agenda she had already committed to during the ‘class struggles’ in the medical sector. According to her, the political basis of the liberation army stemmed from the public universities in the country, places which “(…) morphed into free space to gather, meet and develop emancipatory agendas” (2016). Public universities became the stepping stone to attain the epistemological resources necessary for revolutionary struggles, mainly due to the efficient circulation of Marxist critical literature, and associated socialist/communist scholarship.

The higher education institutions hosted the rise and establishment of the *guerrillas* movement in Bolivia, which quickly became priority targets for state violence. After Che’s assassination in 1967, Hereida said, the Barrientos regime sought to terminate the remaining members of the Bolivian Liberation Army to prevent future upheavals. Throughout the ‘70s, the new authoritarian regime of General Hugo Banzer Suarez continued the pursuit by raiding, dismantling and closing universities. "We fled main cities,” she said, “knowing there was a price on our heads – they sought out to kill…We were persecuted intensively…Our lives were very tough and intense; we were forced to maintain a low profile." Heredia was forced into clandestine life at the Bolivian borders with Chile

and Argentina, but was eventually caught in 1976, and tortured. The significance of her life story still resonates with many ALAMES members today.

c) POLITICAL MILITANCY IN ACADEMIA:

Despite the biographies above, most ALAMES members remained in academia crafting the second fundamental feature of the social medicine *militancia*: the elaboration of a critical epistemology to supplement, strengthen and empower the struggles endured by marginalised social movements. The personal trajectories of the academics were determined by the regional implementation of the *Plan Condor* (Operation Condor) – the US-government strategy to coordinate the actions of all military dictatorships in the southern continent. Mario Rovere, former ALAMES general coordinator, and professor of Public Health at the Universidad de Lanus, argued that *Plan Condor* aligned state terrorism, repression, persecution, kidnap and murder across countries like Argentina, Brazil, Chile, Paraguay and Uruguay (2018a). The strategy belonged to a broader scheme of foreign policies, advanced to mitigate and neutralise democratic socialism, *guerrilla* wars, and popular protest in the context of the Cold War. Edmundo Granda, Ecuadorian physician, former PAHO representative at the Sandinista government and honorary member of ALAMES wrote:

> *"(…) dictatorships and state of emergency became the norm in Latin America, as the dominant form of bourgeoisie democracy. The left-wing comrades that managed to save their lives sought refuge in countries where they could still breathe. The social medicine pioneers of the time…had to flee upon realising the massive assassination of social leaders…The popular movements were swept away while the nightmare of the Latin American holocaust of the left-wing politics continued" (2009a:44)*

According to Granda, the repression of the imperialist bourgeoisie and government authoritarianism in Latin America led left-wing political leaders to exile their home countries. Taking advantage of the relationships established through the social medicine network, various ALAMES members found job security and financial stability in universities that still maintained relative autonomy – predominately, the UAM-X in Mexico and the UERJ in Brazil. Despite the extensive harm state violence procured on ALAMES members, Granda argued that the forced exile paradoxically enabled the consolidation of the thought style due to the similar training the physicians received under the PAHO social medicine programmes. Following the intellectual trend of the era, the social

medicine programmes sought to "(…) produce scientific interpretations about health from the social sciences by introducing Marx and Lenin into the field" (Granda, 2009a:45). The goal was to achieve the emancipatory objectives of the popular movements while nurturing health research with the 'revolutionary advancements'. The social sciences, therefore, acquired central importance for the collective health movement to enhance the vindication of population health struggles through the integration of a more critical social theory into medical epistemology. Saul Franco, founder member of ALAMES and the association's former general coordinator, was an example of the social medicine militancy in Latin American academia.

I met him for an interview at his flat in Bogota, Colombia - the top floor of a modern building in a high-end neighbourhood of the city. The space was ample and well-decorated, with minimalist interior design surrounded by wide windows that provided a lovely view of the city. Its beauty was enhanced by the vintage piano near the entrance, adding a nice touch of class and elegance to the room. The encounter felt quite peculiar, as Franco's persona contrasts the other ALAMES militants I met during the XV ALAMES Conference in Bolivia (most of them belonging to a more discreet socioeconomic background). Franco gave the impression of emerging from a distinctive strand of the social medicine, one that was less radical against *Desarrollismo*. Confirming this perception, he stated during our conversation: "ALAMES is not an anti-movement. It is a movement constructing a broader perspective on health, more comprehensive, more analytical and more transformative of the processes in society" (2018). The statement was exceptional, considering the strong anti-capitalist and anti-US stance widely encountered throughout the ALAMES narrative.

Image 3.3. Online introductory course on Latin American Social Medicine 2018, Session 1 'Introduction to the social medicine perspective.' Conversation between Dr. Saul Franco (left) and Dr. Ana Lucia Casallas (right, former ALAMES Coordinator) as part of the academic resources to the students. Source: Franco, 2017a.

Franco began his academic journey in the philosophy undergraduate programme at a public university in his native Colombia, during the country's uprising of *guerrilla* groups. Though he switched careers to become a medical doctor in the mid-1970s, Franco dedicated his interest to the integration of philosophy into medical thinking following in the steps of Dr Hector Abad Gomez, his mentor, and renowned social medicine leader. Prompted by Abad, Franco joined the newly-established Master's in Social Medicine at the UAM-X on 1978. He focused his thesis on the theoretical basis of social determination of malaria across Latin America, applying a Marxist approach to the analysis of infectious diseases (Franco, 1990). He then extended the interdisciplinary ideas into empirical research in Colombia, interestingly supported by the WHO, the World Bank and other national institutions. This research experience would prove pivotal for being drafted to García's Latin American social medicine network, participation in the early Social Medicine Seminars, and his involvement in the establishment of ALAMES in the '80s. Franco was the first general coordinator of ALAMES after the foundational Ouro Preto meeting in 1984, and has had a prolific career as a researcher in his country.

In 1987, a few weeks after the first ALAMES International Conference in Medellin, Colombia, Dr Hector Abad Gomez, then an honorary member of ALAMES and keynote speaker at the conference, was murdered by paramilitary groups in the region. He joined the long list of health scholars in

Colombia, including Leonardo Betancourt and Pedro Luis Valencia, slaughtered by armed groups for their socialist convictions. The event changed Franco's life, as he explained: " Following the murder of Hector Abad, I found out I was next on the target list. I had to flee the country to find refuge. ALAMES greatly helped by bringing support elsewhere" (2018). For Franco, the network of academics in the collective health movement was pivotal to the survival of many of the social medicine members during the times of political persecution and violence across the region. The support of the Latin American social medicine network, he added, made the collective health movement an ethos whose fraternity extended beyond merely academia. Through ALAMES, Franco migrated to Brazil and enrolled at the Fundação Oswaldo Cruz to complete his fully-funded doctorate degree. “ALAMES as a movement grounded the political struggle not merely in major themes like the broader vision of epistemology, the right to health, or gender equity … but also in fundamental practices of solidarity towards each other”, Franco concluded. The academic explained that the dramatic experience of exile and violence redirected his interest towards the relationship between armed conflict and health, the topic of his doctorate research, and the theme of the centre he helped establish in Rio de Janeiro (Centro Latino-Americano de Estudos de Violência e Saúde Jorge Careli).

Like Franco, many other ALAMES members benefited from the social medicine network of solidarity in times of dire conflict. Alicia Stolkiner, professor of psychology at public Universidad de Buenos Aires, and former ALAMES general coordinator, fled to Mexico following the military coup of *la Junta Militar* against the left-wing Perónismo government of Maria Estela Martinez de Perón in Argentina. Stolkiner completed a Master’s in Clinical Psychology at the Universidad Nacional Autonoma de Mexico, and was militant in the *Movement of Argentinian Mental Health Workers,* where she supported communities that had suffered the atrocities of the military regimes in South America. Through the *militancia*, Stolkiner connected with social medicine pioneers Sylvia Berman, Marie Langer and Ignacio Maldonado, and joined the broader social medicine network. With the advent of the Sandinista Revolution, social medicine researchers came together to create the UAM-X division of Mental Health professionals, established to articulate and support the Nicaraguan Health Ministry’s programmes that were helping vulnerable communities during the post-war phase. Stolkiner was drafted into the Nicaraguan mental health research team, enabling the development of a career and financial stability to sustain herself outside of the military authoritarianism of her native Argentina.

Similar to Franco, Stolkiner considers herself "not radical, but simply a left-wing militant" (2018). During our interview, she disclosed heavy family influences towards revolutionary efforts. She belongs to a second-generation Russian Menshevik migrant community in Argentina which had fled political persecution by the monarchy after the failed uprising of 1905. Once established in Argentina, and dissenting with the Bolshevik Revolution, Stolkiner's family joined the Yrigoyenist political movement during the first wave of the populist governments in the region. She joined the public Universidad de Cordoba during the emblematic events of the *Cordobazo,* a popular insurrection in Cordoba, Argentina, against the military dictatorship established in the 1966 coup. "The *Cordobazo*," she said, "profoundly influenced my professional development, as it amalgamated a milieu of fruitful debate, critical analysis and revision of the theoretical and institutional basis of academia" (2019).

Her experience at the university reinforced her tendency to join popular struggles, and uphold emancipatory ideals, particularly resisting the emerging mental health diagnostic manuals, and in support of the anti-psychiatry movement. Stolkiner completed the psychology programme at the Philosophy and Humanities Faculty, which, in contrast to the traditional Psychology Faculty, enabled her to approach health from a range of disciplines, including philosophy, history, and sociology. All these opportunities crafted a professional profile that integrated concerns for Marxist-Lacanian psychoanalysis, the intervention on socio-political processes, and an early focus on interdisciplinary scholarship. The purpose of incorporating social sciences into health research followed her academic trajectory, and lured her into an active leadership role in the ALAMES militancy.

Hugo Mercer, the Argentinian sociologist and founding scholar of the Master's in Social Medicine at UAM-X, also argued that the social medicine postgraduate degrees were propitious scenarios for the gathering of academics fleeing state violence and persecution (2015). As described in previous chapters, the programmes were established and co-coordinated by the PAHO Department of Human Resources in the 1970s. Interestingly, Ramon Villareal, the former director of the PAHO department in the late 1960s presented in the introductory chapter, brought in critical social medicine as a basis for the academic programme. Villareal was a Mexican physician and public health scholar. He drafted collective health pioneers, including Juan Cesar García, Miguel Marquez, and Jose Teruel into his team. In the early 1970s, Villareal moved on to become the Chancellor of

UAM-X, continuing close relationships with the PAHO department, run by Juan Cesar García. The connections were pivotal for the expansion and consolidation of *Latin American social medicine network*.

Villareal helped organise the early social medicine meetings in Mexico that preceded the establishment of ALAMES. This included the first seminar of Social Sciences Applied on Health in 1974, when academia was hostile towards Marxist epistemology. The meeting was an essential networking scaffold that connected a large number of researchers and practitioners around social medicine. Villareal also joined with Juan César García and Maria Isabel Rodriguez to establish the first Spanish-speaking Master's in Social Medicine at UAM-X. By designing and implementing the postgraduate degree, Mercer added, Villareal and García prioritised job offers to scholars escaping state violence. Mercer himself, for example, took advantage of this opportunity after he received several threats from the paramilitary groups of the Argentina *Junta Militar*, some of which resulted in the murder of his close relatives. A similar case occurred with Argentinian physician and sociologist Juan Carlos Escudero, who found protection and professional continuity as staff of the UAM-X programme (Escudero, 2015).

Additionally, Villareal's leadership of UAM-X granted the Social Medicine Department outstanding economic support from the Mexican government, the Mexican Health Ministry, and CONACYT (the most significant funding body for higher education in Mexico). These efforts resulted in the establishment of a scholarship fund for international students across Latin America, primarily those applying for refugee status. During the socio-political turmoil of Ecuadorian dictators Guillermo Rodriguez Lara and Alfredo Poveda in the 1970s, Jaime Breilh benefited from this scholarship to study at UAM-X, alongside other social medicine members such as Saul Franco, and Sergio Koifman. Edmundo Granda, also fleeting the difficulties of the military dictatorship in Ecuador during the mid-1970s, found support through PAHO to complete the Master's in Social Medicine at the UERJ in Brazil (Betancourt, 2009).

Latin American social medicine militancy, therefore, permeated in ALAMES as a dual endeavour that required a closeness to social struggles, and the support of emancipation through the integration of social theory in academia. Laurell stated: "(…) during the formative stages of ALAMES…Latin American social medicine acquired a practical commitment towards popular

movements….everyone understood themselves as the *organic intellectuals* of the working class and popular sectors" (2011a; see also Laurell, 2018b). Members of social medicine *en-route* to the establishment of ALAMES in 1984, Laurell continued, viewed the collective as the embodiment of the class-struggle, contributing to the ideological basis of the movements against state authoritarianism across Latin America. The Gramsci-inspired term 'organic intellectual' used by Laurell captured the aggregation of academic work, and articulation of popular processes within the ethos of the ALAMES collective.

As Breilh stated: "Our epistemological duties and methodological refinement, though it embodies serious academic challenges, must be made…alongside the social organisations facing the struggles, and without isolating ourselves" (2010:92). Rather than an exclusive focus on academic efforts, Breilh carefully argued that the 'organic intellectual' in the ALAMES *militancia* fully embraced the embeddedness of the Latin American context and its history, opposing the sterile nature of the armchair intellectual. According to Ana Lucia Casallas, former ALAMES general coordinator and public health lecturer at Universidad Del Rosario in Colombia*, militancia* must experience life with laypeople to acquire political thrust and to comprehend reality better (2018). The ALAMES militancy must construct rationale and practices based on the values, concerns and objectives of revolutionary groups on the ground in order to transform the reality interpreted through Marxist lenses effectively.

For Casallas, the goal of becoming an 'organic intellectual' is for people to reason about reality beyond the individual or personal level, and to get closer to concerns of the population. In this way, Latin American social medicine assumed the descriptive functions of theory while simultaneously inspiring social change (see Tajer, 2004). The centrality of the organic intellectual establishes a clear difference of ALAMES with other collective health associations in Latin America including ABRASCO. For the latter, despite close ties with political leaders such as Sergio Arouca and Hesio Cordeiro, the development of the field in the last two decades largely translated into academic excellence and professionalisation in the form of production of peer-review publications, organization of conferences and scholarly events of outstanding scholarly level, management of high impact journals, development of internationally renowned graduate programs, amongst others. Devout attention to academic excellence, nevertheless, runs the risk of coming close to the sterile nature of the office-based researcher – that is to say, despite great relevance in scholarly domains,

professionals may have little impact on societal affairs. For ALAMES, the nature of their work must be the exact oppose. The collective's organic intellectual points directly to the prevalence of political goals and articulation with grassroots movements as a matter of fundamental ethics and principles. Rather than setting up academic programs or scholarly events, the priority in ALAMES is to remain connected to social movements whose focus is largely political (not academia).

III. THE INCORPORATION OF A CRITICAL SOCIAL SCIENCE INTO ALAMES:

a) THE CRITIQUE OF PREVENTIVISMO:

As explored in the previous section, the ALAMES militant was created as a necessary ethos in social medicine to effectively support a region characterised by *Desarrollismo*, oligarchy, state violence, subordination to a US agenda, and various dictatorships. The social medicine persona combined the militancy of social struggles with the academic integration of social sciences in health. However, a crucial element of the ALAMES *militante* is the recourse to, and application of, a critical type of social theory that made sense of the context, interpreting experiences and proposing political action: an anti-American, anti-capitalist and anti-biomedical way of thinking, based on Marxist historical materialism. The last section of this chapter examines the integration of historical materialism as an approach deemed necessary for a militant doctor to act in the reality of Latin America. Most importantly, it will explore: (i) the social medicine critique of the social sciences dominant and pre-existing in the region, the *Preventivismo* or traditional Public Health; and (ii) the tensions underlying the application of an alternative social theory, vis-à-vis pre-existing social sciences in health.

The main focus of the *Desarrollismo* critique by ALAMES was aimed at public health practices and ways of thinking imposed by the socio-political milieu of twentieth-century Latin America. The *Salud Publica Desarrollista* or Development Public Health, also conceptualised as 'preventive medicine', refers to the dominant discourse in the health institutionalised across the continent. Rather than concerns and interventions on the social processes that determined health, traditional public health

consisted of vertical, disease-oriented and cost-effective approaches, including vaccination, drug programmes, prophylactic treatment, and screening for early pathogenic processes.

Laurell affirmed that institutionalised public health in *Desarrollismo* "was based on the biologic medical model, understood as the medical practices whose type of scientific knowledge exclude any mediation of social processes in population health" (2011a). The tendency in preventive medicine was to conceptualise health and disease exclusively in biological terms, at the cost of an in-depth understanding of the social processes associated with health such as power asymmetries, structural injustices and systematic oppression. Laurell explained that, in 'medicalising' life, society devotes its sole attention to medical practices, drugs and health technologies, and therefore neglects the claims and vindications of the social movements and popular struggles. Acting on health inequities through the technical endeavours of biomedicine not only abandons broader literature in social medicine, but also labours on a mismatch in the way society could satisfy basic population needs. Sergio Arouca, Brazilian physician and political leader, wrote:

> *"Preventive medicine as a discursive formation emerges from the confluence of three strands of thinking: the first is social hygienism, which made its appearance in the nineteenth century closely linked with the development of capitalism and liberal ideology. The second is the discussion of the costs of healthcare services during the 1930s-1940s in the United States…And the third is the rise of a redefinition of medical responsibilities consolidating within medical education" (1975a:66).*

Arouca's emblematic book *O Dilema Preventivista* (1975a) was one of the initial social medicine publications that critically analysed the implementation of traditional Public Health. The work was the result of his doctoral thesis at Universidade Estadual de Campinas (UNICAMP), conceptualising public health in Latin America as a type of 'medical attitude and practice', adapted from the US preventive medicine ideology that dominated health research in the mid-twentieth century. For Arouca, the application of preventive medicine in Latin America, differentiated through the term *preventivismo*, reconciled the strands mentioned in the quote in three ways.

First, *preventivismo* substituted the essential goals of nineteenth century social medicine, from concerns about the underlying social processes in health, to acting on the 'superficial' factors of social conditions – including hygienic environments, provision of healthcare, and early detection of

infectious threats. Second, traditional public health responded to increasing healthcare costs by constructing standardised medical knowledge, based on pathophysiology and the natural history of diseases, which enabled the rationalisation of healthcare decision-making for welfare states. Lastly, preventive medicine transformed the healthcare discourse by implementing a new type of medical responsibility that examined individual health at earlier stages of illness in order to tackle hazards in advance. At the heart of Arouca's analysis of *preventivismo* lay the awareness that the development public health did not come by way of hospital practices or institutional reforms – but rather by targeting health epistemology through the transformation of medical education. To match the challenge, Latin American social medicine devised an 'ideological clash' against the positivist, biological and empiricist way of reasoning coming from the US preventive medicine.

Arouca was a co-founder of ALAMES, and is considered one of the most influential intellectuals in the Brazilian *Sanitarista* movement which brought about the healthcare system *Sistema Unico de Saude* in the late 1980s. He graduated from medical school in 1966, shortly after the establishment of the Brazil's repressive military dictatorship led by Humberto de Alencar Castelo. As Arouca explained, the regime imposed the *Desarrollismo* policies in the country, establishing a series of preventive medicine departments in various state universities that replicated the changes in US medical education. Likewise, *Desarrollismo* created the *Instituto Nacional de Assistencia Medica e Previdencia Social* (INAMPS or National Institute of Medical Services and Social Welfare), a 'public health' institution dedicated to the provision of healthcare services across Brazil, albeit restricting healthcare benefits to the working class.

Though the provision of services was pivotal for the recognition of civil rights, the restricted access and limited effectiveness of the INAMPS created tensions that enabled the emergence of the *Sanitarista* movement in the 1970s (see chapter six). Arouca wrote: "The movement of the sanitary reform was born within the perspective of struggle against the dictatorship, a front for democracy to work at sites of the institutional void" (2013). Arouca recognised that *preventivismo* was an issue on two fronts: the skewness in the provision of medical services, and the struggle against the authoritarian regimen that neglected the betterment of social, economic and political conditions. The social medicine epistemology, in this way, called for the integration of both medical knowledge and a social sciences critical approach to tackle the challenges in Latin America.

Arouca's *militancia* began with a postgraduate degree in social sciences at UNICAMP, where he linked his work with the struggles of the Brazilian Communist Party (Rahal, 2009). In the late 1960s, Arouca joined the staff of the Preventive Medicine Department at the UNICAMP, where he began the critique of, ironically, the preventivist model (Galeano et al., 2011:299). Throughout the early '70s, Arouca contributed to the integration of Marxist critical theory into health research from the *Laboratório de Educação Médica e Medicina Comunitária* (Medical Education and Community Medicine Laboratory or LESM). Typical of dissident hubs across the region, the LESM was an independent research centre, experimenting on the extension of critical theory and alternative approaches in health.

The heightened repression in Brazil in the second half of the '70s led to the closure of the LESM, and drove academics into clandestine lives. Arouca continued to bring together Marxists scholars on health-related topics through the underground operations of the newly- established *Centro Brasileiro de Estudos de Saude* (CEBES or Brazilian Centre for Health Studies). After completing his doctoral thesis in the mid-1970s, the escalating conflict in Brazil motivated Juan César García to bring Arouca into PAHO as a health consultant to the Sandinista government in Nicaragua. Arouca remained there until the weakening of the Brazilian dictatorship, the re-establishment of democracy, and the triumph of the *Sanitarista* movement in the 1980s.

Image 3.4 Dr. Sergio Arouca speaking at the 8th National Conference in Health in 1986 (8a Conferencia Nacional de Saude). The conference is emblematic as it inaugurated the plans for the National Healthcare System in Brazil SUS. Source: Abreu and Franco, 2014

Preventive medicine in Brazil was founded at the Universidade de Sao Paulo (1954), and Universidade Federal de Minas Gerais (1958), parallel to the introduction of the ideology through PAHO-sponsored seminars on medical education at Viña del Mar, Chile and Tehuacán, Mexico. The transformations in the state's medical curricula were intensified during the period of military regime, at places like the Faculdade de Ciências Médicas da Santa Casa de São Paulo, the Faculdade de Ciências Médicas de la UNICAMP in the 1960s, the Universidade Federal do Rio de Janeiro, and the Universidade Federal da Bahia in the early 1970s (Arouca, 2013; see also Duarte-Nunes, 2016). Arouca argued that *preventivismo* pushed the boundaries of healthcare services to intervene in earlier stages of a disease - before signs and symptoms manifested in the body. The underlying purpose of the endeavour was to maintain high productivity among the industrial sector. In other words, preventive medicine made healthcare an auxiliary to the growing labour exploitation.

Arouca argued that the 'dilemma' of *preventivismo* was precisely that the approach did not fulfil the promise that justified its introduction, mainly, a real transformation of therapeutic practices. Instead, developmental public health represented an extension of the same curative logic in pre-pathological stages of illnesses, strengthening the emerging market healthcare system, and reinforcing the prevalence of private clinics and services (Arouca, 2013). *Preventivismo*, conclusively, was merely an ideological move to transform the so-called 'medical attitude' towards lifestyle and behavioural risk factors (1975a:112).

For Arouca, the positivist character of preventive medicine stemmed primarily from being rooted in the natural history of the disease model sponsored by Leavell and Clark (1965). This paradigm considers "morbid conditions as the result of a process that follows a process in the environment and within man until the affected individual either returns to normality, attains a state of equilibrium, or dies" (Arouca, 1975a:144). Arouca argued that Leavell and Clark's model represented a mechanistic explanation for illnesses, based on a biological cascade of events that resulted from the interaction between the individual guest and a disease agent. Such a linear understanding of the health and disease process came from a specific type of social science - the American structural-functionalism of Talcott Parsons, John Simmons, and Edward A. Suchman that forcefully displaced considerations on the sociohistorical basis of health (Arouca and Marquez, 1974). In the US, preventive medicine sponsored functionalist approaches developed within sociological studies of individual lifestyles. Arouca believed that preventive medicine stood at odds with societal-level analysis and interventions, which limited the role of the state to the promotion of civil society organisations and private enterprises. These he saw as aligned with the capitalist context of twentieth-century America (see also Mercer, 1986). P*reventivismo* therefore stripped 'public health' from broad societal action on underlying economic, political and cultural processes, limiting its role to the expansion of individualised and curative healthcare.

Jairnilson Silva Paim and Naomar Almeida-Filho (2001), both prominent scholars of the Brazilian collective health movement, explained that the affairs of twentieth-century US were pivotal in the development of traditional public health in Latin America. At the beginning of the century, the Carnegie Foundation commissioned American researcher Abraham Flexner to assess medical education across the US, yielding the so-called Flexner Report in 1910. This work revitalised the scientific bases of health by advising universities and health centres to standardise medical practices

using rigorous technical principles based on the natural sciences. The Flexner model, Silva Paim and Almedia-Filho explained, prompted a more efficient way of generating knowledge in health by emphasising the artificial separation between the individual and collective, the private and the public, the biological and the social. According to Breilh, individualist approaches, like the germ theory, constituted the historical basis for the scientific paradigm sponsored by Flexner, who "…drastically closed the possibilities of a social world in health, and focused exclusively on biological thinking" (2003a:140).

Following the success of the report, various philanthropic branches of corporations, such as the Rockefeller and Kellogg Foundations, funded massive reforms in the US medical curricula to fit the Flexner model. These changes were labelled 'preventive medicine', and extended across the country during the 1940s. The thrust of the reforms acquired international proportions, with the 1952 Association of American Colleges Conference on Medical Education at Colorado Springs serving as the scaffold for PAHO to expand the proposal across Latin America, by way of the seminars in Chile and Mexico. Juan César García added:

> *"Latin American medical education was considered to be scientifically backward, disjointed from prevention, undisciplined, and methodologically anachronic. The PAHO, the Rockefeller Foundation, the Milbank Foundation, and Point IV Programme joined efforts to correct these deficiencies. The PAHO took charge of 'modernising medical education on prevention and society.' The Rockefeller Foundation created and supported different standards of medical schools in areas relatively isolated from the big urban centres. The Milbank foundation focused on the social sciences in health. And Punto IV incorporated social scientists, particularly anthropologists, in its plans for action" (2007:154).*

García took the view that the 1950s *Desarrollismo* enabled international health organisations to achieve the reformulation of Latin American medical education to preventive medicine. By doing so, it took advantage of the region's economic dependency, and its socio-political vulnerabilities. He argued that the organisations legitimised *preventivismo* as the most appropriate solution to the promise of growth and progress through development policies. In essence, the rationale and practices of traditional public health made invisible the social concerns and claims made by ongoing populist protests, circumscribing health epistemology to curative practices alone, and enabling the advancements of the early capitalist model in health. García criticised the pretentiousness of the international bodies which, claiming ownership over medical knowledge, advanced very influential

discourses to 'let the market run its course' so that healthy conditions emerged naturally from the growing financial sector. All foreign organisations referenced by García in the quote above, corresponded to either philanthropic arms of multinational corporations, or US-government associated programmes with existing investments in the region that aimed to expand their markets. García's iconic publication *La Educacion Medica en America Latina* (Medical Education in Latin America, 1972), which resulted from the Harvard-PAHO commission to evaluate medical education in the continent, corroborated the resounding success of the imposition of *preventivismo* by the international health organisations (see also Duarte-Nunes, 1991). For Arouca, therefore, the success of *preventivismo* stemmed from the predominance of the ideology in core countries of the global capitalist system, which trickled-down the approach to the 'periphery' - colonising the medical epistemology of the subordinated Latin American society.

To differentiate local social medicine more clearly, the ALAMES collective has invested substantially in othering the international health organisations as foes. The Rockefeller Foundation and its relationship with the *Salud Publica Desarrollista* illustrates the point. According to Mario Rovere, former ALAMES coordinator and head of the Health Department at the Universidad de Lanus in Argentina, John D. Rockefeller's businesses in the US gained copious wealth through questionable practices, including the dispossession of land, labour exploitation and corruption. Rockefeller created a foundation to appease crowds protesting against his corporation, and to restore his public image in society. Specifically, the industrialist found his niche of redemption in medical education, hiring Abraham Flexner to construct a new type of healthcare practice, so-called 'standardised medicine.' Flexner unified all elements of the dominant health epistemology at the time, into the constitution of "(…) a pure medic, that is to say, a physician intentionally built to favour the financial interests of the Rockefeller corporation" (Rovere, 2016). According to Rovere, the Rockefeller medic embodied the features of preventive medicine to become an individual wholly detached and uninterested in the social struggles of the context, and heeding exclusive attention to the basic sciences of health and the biological processes of disease. A Rockefeller medic, Rovere added, was a hospital-based and technology-dependent 'technician of the body,' inhibited from making the necessary inquiries about the social basis of health. "And this is where the famous saying about physicians comes to bear," Rovere concluded, "that everybody that sees a dangerous curve on the road places barriers to prevent the fall – except the medic who owns the hospital at the base of the hill" (2016).

In the eyes of the ALAMES collective, the Rockefeller medical persona was expanded and imposed on the epistemological colonialism of international health organisations throughout Latin America. García argued that the Rockefeller Foundation was pivotal in the completion of the US government's imperialist goals in the region (2016:162). During the first half of the century, the foundation's philanthropy partnered with local governments to fund various healthcare projects to advance its own objectives (García, 1983). Foreign philanthrocapitalism by the hand of Rockefeller established a whole network of health institutions and programmes across the continent, including national Health Ministries, public health departments, vector-borne control strategies, and various research grants to conduct evaluations on population health. According to Garcia, the foundation particularly focused on the institutional void at sites of resource extraction (which fed into Rockefeller Corporations), establishing the healthcare infrastructure necessary to maintain services for workers. By strengthening the control, treatment and prevention of tropical diseases – such as Anchylostomiasis, Malaria, Yellow Fever, and Dengue – Rockefeller sought to expand oil sites, maintain working labour, and capture new markets like cotton, coffee, rubber, and mining. The tension in Rockefeller philanthrocapitalism, therefore, lies in the significant success of the vertical and disease-based approaches for the betterment of population health – but motivated by secondary financial goals through sustained high productivity (Franco, 1990; Rovere, 2016; Feo, 2018b).

The collective health critique not only focussed on international health organisations, but also questioned the epistemological basis of traditional public health in medical education. Alicia Stolkiner and Sara Ardila Gómez highlighted how the introduction of *preventivismo* met massive resistance by social mobilisation and revolutionary movements, "generating the conditions for a cultural critique of the hegemonic paradigms" (2012:6). The dominant approaches were considered insufficient to account for the problems in Latin America, where the gap of social inequalities deepened during the model of economic growth. The scenario of protests and insurrection, mainly supported by public universities, provoked a definite rupture of social medicine from preventive medicine, reframing the collective health movement as the opposition to the dominance of *preventivismo*. Stolkiner and Ardila point out that *preventivismo* applied the social sciences found in the so-called Ciencias de la Conducta, or behavioural sciences, from US scholarship (2012:8).

Continuing the accounts on behavioralism explored in chapter two, Duarte-Nunes explained that the characteristic feature of behavioural sciences was the dissociation of individual behaviour from social embeddedness which enabled medical intervention through therapeutic practices. "[Behavioural sciences] postulated that the necessary changes for the betterment of our current health status were not a transformation of the social structures, but rather the transformation of individual behaviour and, if possible, of health institutions" (Duarte-Nunes, 1991:37). In other words, the behavioural sciences worked under the assumption that health and disease were mainly a matter of personal responsibility, orienting institutional efforts towards the management of conduct, habits, attitudes and motivations (see also García, 2007:155). Agreeing with Arouca, Duarte-Nunes clarified that the social sciences of behavioralism relied heavily on Parson's structural functionalism, Leavell and Clark's natural history of the disease, and the economic rationality and organisational strategies upon healthcare services (2016).

For García, the Latin America context at the end of the 1960s was strongly opposed to the goals of preventive medicine as social movements perceived this ideology as halting the equal distribution of resources (1983). The emerging responses to oppressive foreign policies, and the economic crisis of capitalism in the early 1970s led Latin American social medicine to criticise the positivist notion of a universal health science wholly detached from the context and its history. The collective health opposition, García clarified, consisted of rejecting the idea that knowledge in health could be stripped off values and principles to become 'objective' and 'unquestionable.' Breilh added: "(…) during the formative period of ALAMES, an academic rupture occurred against the biomedical model, the empirical methodology of positivism…and the functionalism-behavioralism of the social sciences" (2018a). Contrasting traditional public health, Breilh explained that social medicine devoted to the construction of a 'new objectivity in health', which critically analyses the dominant notion of risk factors, reformulates causality in health, and introduces Marxist approaches to the comprehension of the health and disease process (see also Breilh, 2003a:36). Rather than denying the benefits of biomedicine, Arouca argued that social medicine redefined health epistemology theoretically and methodologically, to incorporate research concerning both the biological basis of illnesses and the social determination of the health process. In the pluralism of medical knowledge sponsored by ALAMES, the collective health thought style "(…) breaks away from the preventivist ideology and object of study to produce knowledge that contributes to real transformative action" (Duarte-Nunes, 1991:33).

b) FROM PREVENTIVISMO TO A CRITICAL SOCIAL SCIENCE OF HEALTH:

Though Latin American social medicine recognised the existence of social sciences in the contemporary medical epistemology, it was clear for the collective health movement that the underlying social theory did not provide resources for a radical social transformation. On the contrary, the functionalism in preventive medicine reproduced the ethos, principles and values of a dominant elite that greatly benefited financially from this way of thinking health. For the collective health movement, therefore, the struggle in health was not the incorporation of social theory *per se,* but the shift into a different type that was more militant, critical and emancipatory. The need was for the incorporation of an anti-capitalist, anti-American and anti-positivist health epistemology. However, the move towards this type of oppositional standpoint in the 1970s was complicated to make due to the medical establishment resistance to change. Mercer added: "(…) various groups were attempting to incorporate another social science in medical schools…The field of preventive medicine was tough to work with, nevertheless, as very conservative people ran the lectures" (2015). Paradoxically, Mercer continued, the same PAHO that helped diffuse *preventivismo* across the region, also collaborated significantly in establishing and consolidating the social medicine network that sought to shift away from functionalism. The goal of social medicine was to integrate a different social theory that had broader perspectives, making health and disease more sociological and less behavioural.

According to Mercer, the alternative Latin American approach proposed the incorporation of other authors previously ignored by *Preventivismo,* including Weber, Bourdieu, Marx, Engels, Foucault, and some earlier work by Boltanski. In so doing, new debates in health were nurtured from topics beyond healthcare and the medicalisation of life, towards the dimensions of corporatist power, asymmetric relationships in the production of knowledge, and the social control of institutions. Laurell added: "We used to call our approach *sociology of medicine*, not because we were in conversation with US medical sociology, but to emphasise that it was not easy to be progressive or revolutionary in that epoch – it was simply a way to peacefully introduce the new social sciences into health" (2013). According to Laurell, the introduction of alternative approaches to the dominant social sciences was revolutionary in that it challenged the status quo in medical practices to the point of meeting overt opposition, and even becoming dangerous to scholars (given the persecution

and violent repression of paramilitary militia by Latin American dictatorships). Laurell explained that the introduction of alternative approaches to the crafting of Latin American social medicine was championed primarily by three scholars: Juan Cesar García, Miguel Marquez, and Maria Isabel Rodriguez. The trio, Laurell added, systematised the distinction of Latin American social medicine with the US behavioural sciences at the first Social Medicine meeting in 1972 at Cuenca, Ecuador.

As explored in the introduction of this thesis, the so-called 'Cuenca I' meeting was organised by Juan César García through sponsorship by PAHO. Aligning with Mercer above, the same international health organisation involved in the expansion of *Desarrollismo* in health was pivotal in the constitution of a new critical social medicine in Latin America. Miguel Marquez explained the situation best when interviewed for the Oral History of Latin American social medicine seminar series by the Institute of Collective Health at the Universidad de Lanus (Argentina) (2015). Marquez, a retired scholar with mid-length curly hair, a long white beard, and a red t-shirt commemorating Barcelona F.C., sat confidently in what appeared to be a teacher's lounge at the university, while slowly smoking a cigarette. His appearance certainly did not fit preconceived ideas of such a distinguished and well-travelled academic, yet what he related was as precious as expected. For Marquez, the 'Cuenca I' meeting was merely the culmination of a long process that began with the Harvard-García research on the status of medical education across Latin America.

Image 3.5 Dr. Miguel Marquez while smoking a cigarette during a 2010 interview organised by researchers from the Universidad de Lanus. Source: Marquez, 2015.

Miguel Marquez was an Ecuadorian physician-pathologist, professor of Public Health at the Universidad de Cuenca (Ecuador), distinguished professor of social medicine at Universidad de la Habana (Cuba), and founding member of ALAMES. Born to a working-class family in Cuenca, Ecuador, Marquez shared his early years with ALAMES colleague and intimate friend Edmundo Granda. His early days in Cuenca planted the seeds of socialism as Marquez's immediate relatives founded the Socialist Party of Cuenca, and taught him about the Bolshevik Revolution, Latin American socialist scholars, and the stagnant context of Ecuadorian politics (Marquez, 2011b:236). It was during this time that essential figures of the belligerent struggles of the Latin American political left, including Ernesto "Che" Guevara and Commander Fidel Castro, permeated Marquez's upbringing and became idols to follow in *militancia*. According to Marquez, his youth years of activism taught him that political action did not emerge from political institutions, but in struggles of people fighting for better living and working conditions on the streets and plazas.

Miguel Marquez, or "Masho" as his close friends called him, graduated as a medical doctor from the Universidad de Cuenca in the 1950s. In the early '60s, Marquez moved to Colombia to pursue further medical training, completing a Master's degree in Clinical Pathology and a postgraduate diploma in Molecular Biology and Electronic Microscopy. Marquez then returned to Cuenca, where he joined his *alma mater* as a member of the teaching staff in structural pathology for undergraduate medicine in 1966-1967, becoming dean of the Health Sciences Faculty between 1967 and 1968. It was during this time that the academic took on the challenges of Latin American social medicine. Marquez said that his time teaching brought him close to the postulates of Rudolph Virchow, first as a pathologist, and then as a social scientist. He said: "(…) I stopped working on anatomical pathology and began scrutinising the body of societies, revising the far-right dictatorial regimes to have clarity on the revolutionary struggles ahead and the materialisation of Marxist-Leninist thinking" (2011b:239). Marquez's political activism was noticeable in his native Ecuador through founding the Ecuadorian Medical Faculties Association, acting as its general coordinator through the second half of the 1960s (Pastrana, 2014). Marquez also joined various student movements like the

University Student Federation, the Ecuadorian Medical Student Association, and other labour unions in Ecuador, remaining faithful to his militancy as an organic intellectual.

His political activism in health opened up an opportunity to join PAHO in 1970 at the Department of Human Resources, under the leadership of Ramon Villareal. There, Marquez pursued a career in public health and healthcare management, researching the methods of promotion and prevention of health in the region. During his stay at the Department of Human Resources, the scholar joined García's research on medical education in Latin America, where he was introduced to *the social medicine network* that was in its early formation. Marquez helped García consolidate the group through PAHO-sponsored medical education research, and academic events that promoted social medicine in the region. He was also PAHO's representative to Guatemala, Nicaragua, and Cuba between 1970 and 1996, particularly during the Sandinista government and Castro regime. As Mario Rovere explained during our interview (2018b), Miguel Marquez was inspirational to various ALAMES members as he was openly engaged with left-wing politics at a time of considerable opposition.

Marquez and García met in the late 1960s when Juan Cesar visited the Universidad de Cuenca in the preliminary stages of medical education research, looking to connect with the medical school. Marquez, who was the dean of the faculty during the military dictatorship of Ramon Castro, at first questioned García's involvement when finding out the Milbank Foundation was financing him. The pressing context in Ecuador merited this apprehension. As Marquez explained, the implementation of the *Plan Condor*, the persecution of socialist-communist scholars, and the holocaust of social movements leaders and left-wing activist had left an extensive scar in the region and the country. The Milbank Foundation was synonymous with the CIA and US imperialism so "…we decided we would give García 24 hours to work with us, but he was considered persona *non grata* for the time" (Marquez, 2015).

Despite the animosity, García's extensive involvement in student movements, strikes and protests in Argentina unveiled the scholar's affinity for socialist politics – a trait shared with Marquez. Interestingly, when Marquez confronted García about his involvement with the Milbank Foundation *vis-a-vis* their political affiliation, García responded: "I know nothing about that tug-war – the only slogan I have is the fight against imperialism. So, this is my little espionage. After all, I am a PAHO

representative as well" (Marquez, 2015). García's comment tapped into the social medicine tension with international health organisations, mainly because the emergence of Latin America's social medicine network was made possible by the same international health organizations the ALAMES collective now criticises. The PAHO and the Milbank Foundation were scaffold networks, and institutional funders of projects that brought social medicine scholars closer together.

According to Rovere (2018b), the tension within ALAMES between social medicine and international health organisations arose from the collective's identity as a socialist-communist group, yet finding the material means for research and networking through right-wing institutions. The apparent contradiction, however, may be resolved through the exploration of the biographical stories of the ALAMES members. Despite being a predominately US-funded organisation, PAHO in the 1960s enjoyed a short but key period of critical thinking, where it reformulated discourses to challenge the preventive medicine paradigm dominant at the time (see Cueto, 2007).

As Galeano and colleagues explained (2011), García and Marquez joined PAHO precisely when the organisation was promoting the development of critical social sciences in health, allowing the experimentation and expansion of historical materialism in health epistemology. Between 1958 and 1975, PAHO was led by Chilean physician Abraham Horwitz, a 'greatly collaborative' and 'a mason like Allende', who shared a high affinity towards social medicine (Marquez, 2015). "Horwitz undertook, as a sort of personal commitment, the strengthening of the human resources area and the scholarship policy, which in turn made possible many of the projects García carried out in Latin America" (Galeano et al., 2011:307). Horwitz's leadership, alongside figures such as Villareal, García, and Marquez helped in the refocusing of international funds to projects sponsoring social medicine, including the social medicine seminars of Cuenca I and II, the social medicine conferences in Nicaragua and Mexico, as well as the establishment of social medicine programmes at UERJ and UAM-X.

Nevertheless, at the peak of the Cuban Revolution influence across the region in the late 1970s, PAHO progressively grew more conservative, and began opposing the socialist policies and interventions previously sponsored. The organisation discarded the bottom-up approaches defended by García and colleagues, forcing Horwitz to favour top-down strategies aligned with *Desarrollismo,* including institutionalised public health programmes and the expansion of

healthcare insurance systems. With the entrance of Hector Acuña as the new PAHO director in 1975, Galeano and colleagues explained that these conservative approaches intensified, and only a small group of officials resisted this shift. The Department of Human Resources, now led by García, remained functional but weakened due to open opposition to the new PAHO regime. The dissident Department of Human Resources continued to support social struggles in Brazil (the *Sanitarista* movement), the consolidation of the social medicine postgraduate programmes in Latin America, the continuation of the social sciences in health seminars/events/publications, and the development of the collective health movement leading up to the establishment of ALAMES (see also Marquez, 2007). The department worked with a lot less funding and more obstacles, but remained faithful to the convictions of the emerging social medicine. Marquez added that the endeavour was carried out 'in secrecy' to secure its continuity throughout the '70s.

Though the ALAMES collective aimed at approaches critical of capitalism in Latin America, the development of Latin American social medicine was integrally linked with the policies and organisations of *Desarrollismo.* For example, despite García's adamant inclination towards social medicine, "both the choice to study sociology and the scholarship provided for graduate education abroad were paths marked by particular university policies related to developmentalism policies [*Desarrollismo*]" (Galeano et al., 2011:286). Elsewhere, García recognised that the work of scholars interested in social medicine and who preceded the social medicine network, emerged from the numerous medical schools which – in the wake of preventive medicine reforms – initially hired social scientists as academic staff (2007:154). The experiment, nevertheless, was fruitless because the hierarchies of authority, and methodological/conceptual differences brought strife between traditional medicine and social science scholars. According to García, the medical staff failed to recognise the potential of emerging interdisciplinarity in health, leading medical faculties to invest exclusively on biomedical approaches. Regardless, García referred to PAHO's medical education initiatives as programmes aimed at an inseparable relationship between preventive and social medicine in Latin America, despite the evident dissociation in the approaches years later. *María Isabel Rodríguez,* cardiovascular surgeon, former Chancellor of the public Universidad de El Salvador (1999-2007), former Minister of Health during the socialist FMLN government of Mauricio Funes (2009-2014), and founder of ALAMES and honorary member, added:

"(…) between 1975 and 1983 was the epoch that enabled the establishment of ALAMES, towards the 1984 conference at Ouro Preto…In Mexico, the PAHO Department of Human Resources organised the first seminar of Social Sciences Applied on Health in 1974 at Guadalajara…Dr. Ramon Villarreal attended the seminar as the dean of the recently established UAM-X at the time, and we managed to generate the most important conclusion of the meeting: the need to create a postgraduate degree on social medicine in Mexico" (2016).

Rodriguez's narrative points at an interesting finding of ALAMES collective history: The very epoch deemed 'most fruitful' also corresponds to the most obstacles for social medicine imposed by Acuña's leadership at PAHO. In this way, despite the challenging milieu among medical schools and PAHO directives to accept the social medicine approach, Rodriguez and colleagues realised the Mexican seminar on social sciences that paved the way for the establishment of the UAM-X social medicine postgraduate programme. According to Rodriguez, "the dean of the Universidad Nacional Autonoma de Mexico even labelled us 'unruly'" (2016). Following ample support by the Kellogg Foundation in the early 1970s, PAHO, and the UN Developmental Department, the UERJ established the first social medicine programme in 1973, which directly linked with social medicine scholars such as Sergio Arouca, *Hésio Cordeiro,* and *José Pelúcio Ferreira* (see also Duarte-Nunes, 1992:48). García, seeking to replicate international support, enabled the expansion of the initiative by assigning Rodriguez to carry out regional meetings on social medicine in Mexico. When she organised the seminar with medical schools, the scholar revealed that Villareal encouraged the integration of the critical social sciences approach in medical thinking, and created the need for postgraduate programmes in social medicine during the event. In his capacity as Chancellor of UAM-X, Villareal took the responsibility of establishing the Social Medicine Department and programme at his institution, beginning in 1975, which benefited the myriad of ALAMES members described in the previous section (see also Rodriguez, 2019).

Interestingly, Rodriguez also described how PAHO's involvement in the development of the social medicine thought style was not merely the provision of financial support, nor the political thrust in social medicine initiatives. Instead, the organisation also worked as the centralising social medicine database, mapping the development of the thought style in Latin America. She explained that the region's social medicine network, though led by García in the '70s, had been under constitution since the decade before. Through the Department of Medical Education, Villareal at PAHO developed the so-called National Medical Libraries programme, a regional project to construct an

extensive bibliography in Spanish on diverse topics including basic sciences, clinical sciences, public health and other interdisciplinary subjects. Rodriguez said: "(the programme) represented a tremendous shock to many sectors that considered medical education as merely constituted by the basic sciences - without contemplating an integral perspective beyond medical practices" (2016).

The Medical Libraries programme identified and documented many people associated with alternative approaches to health sciences, creating a cartography of social medicine across Latin America, and contributing to new research. Beyond academic networking, Rodriguez continued, the people in the programme became 'like a family' who supported each other during times of persecution in the mid-1960s – similar to the description already revised on Garcia's social medicine network in the '70s. So, even before García's efforts to bring scholars together, the endeavour was preceded by Villarreal's Medical Libraries programme. As Rodriguez pointed out: "The Department of Medical Education was already recruiting a matrix of intellectuals in the medical field, a hub of scholars led by Ramon Villareal" (2018a). It was with this matrix, she explained, that García gained a roadmap to begin his studies on medical education in 1967, and establish the basis of the *Latin American social medicine network*.

Rodriguez has been honoured with multiple distinctions across Latin America. She was decorated as the Public Health Hero of the Americas award from PAHO/WHO in 2015 (the highest distinction given by the international health organisation), the Millenial award for the Most Valuable Woman in El Salvador by the Organization of American States in 1999, made an Honorary female member of the Spanish National Academy of Medicine in 2018, and received a Doctorate *Honoris Causa* from more than twelve universities in the region. Rodriguez has authored and co-authored over 100 publications on topics ranging from cardiovascular health, the development of human resources, medical education, international health, social medicine and university management. She is, additionally, the last honorary and founding member of ALAMES to remain alive, as García passed away in 1984, and Miguel Marquez in 2013.

Image 3.6 ALAMES members at the 2016 XIV ALAMES International Conference at Asuncion, Paraguay. Panel titled 'ALAMES Historical Review, 30 years of Development.' From left to right, Dr. Eduardo Espinoza, Dr. Maria Isabel Rodriguez (speaking), Dr. Nila Heredia, and representative of the Salvador Allende movement from El Salvador. Source: UIESP El Salvador, 2016

Chavelita, as her friends call her, was born to a sizeable matriarchal family in 1922. "My mother thought that my vocational orientation was teaching," she explained in an interview for PAHO, "but I grew up in a household with cousins that studied medicine … so the interest for medicine emerged from imitating my cousins and finding encouragement in their friends" (2018b). Rodriguez challenged the male-centred status quo of El Salvador by joining the medical school, and becoming one of the first three women to complete the degree in the country. Her *militancia* began during medicine, where she joined various student movements, and wrote opinion columns against the dictatorial military regime of Maximiliano Hernandez Martinez (1931-1941). As she said: "It was a favourable environment to incorporate in the efforts of social struggles … the university became a hub for alternative ideas in many different spheres" (2018a).

On graduating with honours as a physician, Rodriguez moved to Mexico to continue her clinical training in cardiology, followed by a subspecialty in Electrophysiology and a postgraduate degree in Cardiovascular Physiology at the National Institute of Cardiology in Mexico (1949-1954). She

returned to her native country the same year to join the teaching staff of the Medical Faculty at Universidad de El Salvador. In 1967, the scholar was appointed Dean of the medical school, becoming the first woman in El Salvador to hold this position. Her time at university was significant, providing the opportunity to move beyond academia, and deal with affairs of medical education. She directed essential transformations in the medical curriculum, focusing predominately on preventive medicine and the promotion of health. The changes came during the epoch of *preventivismo* in El Salvador, and the proliferation of institutionalised public health in medical schools after the Viña del Mar and Tehuacan meetings. Rodriguez added: "We had great support from a myriad of organisations on strengthening the basic sciences, including the Rockefeller Foundation, Kellogg Foundation and many others. On fields like public health, we received support from the PAHO" (2018a). This remark makes evident both the active participation of the international health organisations, and the division of roles along political interests. Similar to Marquez, Rodriguez was then approached by García to plan and collect data on medical education in Latin America.

Rodriguez's life was also shaped by the context of violence in the region. Her years as Dean were characterised by struggles against frequent raids perpetrated by the authoritarian regime in El Salvador. In 1972, the military government of Arturo Armando Molina stormed the university with advanced weaponry, tanks, and troops, forcing its closure, and persecuting the leaders that had promoted reforms. As a result, Rodriguez left the country that year, fearing for her safety, and with an offer from García - a job at PAHO's Department of Human Resources. For the next two decades, she developed as a PAHO representative in Mexico, Haiti, Venezuela, and Dominican Republic, amongst others. Rodriguez founded and directed the International Health Training Program at PAHO in the mid-'80s, which connected her with other scholars of the ALAMES collective, including Mario Rovere, and Oscar Feo. Her influence in ALAMES lives on through the continuous involvements in social medicine programmes and events.

IV. CONCLUSION:

This chapter assembled the biographies of ALAMES members to present the collective biography pertaining to Latin American social medicine. The key objective was to unveil the social medicine militant presented as the necessary persona to most effectively tackle the Latin American context in the second half of the twentieth-century. The context is characterised by state violence, persecution, repression, kidnap and murder, embedded in the turmoil of capitalist dictatorships, and thriving health inequities. The first segment of the chapter presented the social medicine diagnosis of Latin America on which the ALAMES militant is constructed. Mainly, the authors unveiled the context through the so-called *Desarrollismo* or developmental policies in Latin America, introduced through the economic subordination of countries to the US. According to ALAMES members, *Desarrollismo* worsened the inequalities between and within countries, by maintaining a global economic order that left Latin America as an auxiliary, and a dependent to the growing industries of the Global North, the foreign investment of monopolistic transnational corporations, and the ever-increasing debt to international financial organisations. As a result of this dependency and the cycle of terror perpetrated by the oligarchic states and authoritarian regimes, Latin America experienced a new wave of social mobilisation and revolutionary movements seeking to vindicate fundamental rights, revitalise democracy and level the field for the vulnerable and the working-class.

Following the wave of social movements and popular protests, the social medicine *militancia* developed two fronts: the national liberation armies, whose basis consisted of the close connections with social struggles; and the academic integration of alternative social sciences in health. The second segment built on this militancy of dual nature to explore the type of social sciences that enabled the interpretation of Latin America, functional for the emancipatory goals of social medicine, and the constitution of an a critical, subversive, and situated epistemology in health. Following the intellectual tide of the era, the collective health movement integrated Marxist historical materialism as an adequate social theory to confront the Latin American context. Most notably, the ALAMES link between militancy and Marxist critical theory emerged as a response against North American social sciences in health, introduced by the developmental public health or *preventivismo*. In creating such a link, the social medicine collective encountered frictions between the political inclination of the members, and the conditions of possibility that enabled the collective health thought style to emerge. Social medicine mainly co-existed with the paradox of opposing the very institutions and policies that contributed to the rise and consolidation of the collective health

thought style in the first place. Critical disruptions in the history of international health organisations were revealed that were fundamental to the creation of Latin American social medicine.

CHAPTER 4

ALAMES AND THE SOCIAL DETERMINATION MODEL

I. INTRODUCTION:

"You will hear everyone in ALAMES talking in similar terms: the social determination of health, the health and disease process, the importance of reading reality comprehensively, the understanding that processes in health are articulated, integrated and subsumed in the socio-economic dynamics, etc. All these things join us together because they constitute a philosophy that is distinctive from the traditional public health dominant in Latin America."

- **Ana Lucia Casallas, former ALAMES General Coordinator, senior lecturer of public health at Rosario University in Colombia. Interview on October 24th, 2018.**

Latin American social medicine considers capitalism to be not merely the socio-economic model organising society towards 'development' and economic growth, but also the dominant way of conceiving the relationship between health and society. As explored in the previous chapter, ALAMES members argue that the rationale and practices of *preventivismo* stem from capitalist development policies throughout the last century, which aligned state institutions, political sectors, national and international organisations, higher education, and the healthcare system towards interpreting life in biomedical terms alone. Capitalism, for the ALAMES collective, is therefore the dominant ideology determining the values, principles and perspectives through which social institutions and individuals think and act upon health and disease.

Ana Lucia Casallas, Colombian nurse, with a doctoral degree in Collective Health, Environment and Society at *Universidad Andina Simon Bolivar* (Quito, Ecuador), and former ALAMES general coordinator; addressed the theme at the XV ALAMES International conference in La Paz, Bolivia.

Casallas explained that social medicine primarily utilises 'capitalism' to capture the power asymmetries, unequal distribution of resources, the repression of subaltern classes, the injustices of gender oppression, the on-going racism, the dispossession of land, the persecution of social leaders, and all other phenomena that impact population health inequities. As Breilh commented elsewhere: "We perceive that our societies reproduce around capital and its accumulation, implying the concentration of advantages and resources for the few at the cost of the majority – ultimately causing dire consequences in population health" (2019). However, the development of the social medicine thought style in the last three decades also pays particular attention to the impact of capitalism on knowledge-practices in health. For ALAMES, 'capitalism' constitutes a worldview that translates into health epistemology in the form of biomedicine or the so-called *Hegemonic Medical Model.* The model has been the point of departure for the social medicine approach to health through the critique of its elements, and its link with the social determinants of health. At the core of ALAMES's critique of biomedicine lies the overarching idea that the capitalist hegemony co-opts knowledge production to focus exclusively on mechanistic explanations of disease through biological accounts, while simultaneously neglecting the underlying social processes and contextual realities determining the conditions for population health.

Responding to the capitalism in health epistemology, Casallas explained that social medicine brings an alternative way of thinking about the social basis of population wellbeing, grounded in the situated experiences of the Latin American context. The social medicine epistemology (i) makes sense of the immediate reality of individuals and communities, (ii) interprets the systematic oppression, structural injustices and power asymmetries of contemporary Latin American societies and (iii) proposes different ways of governing collective action in health that are relevant at the local level. According to the social medicine collective, the main difference between the epistemological theses of ALAMES and the dominant public health tradition is that the former aligns health thinking with the struggles highlighted by social movements in ways that the latter approach is incapable of doing. Following Casallas, the social medicine critique of biomedicine synthesises the accumulated experience and embodied perspectives of ALAMES during the early years of the collective health movement – perceiving the hegemonic model as a means for social control and status asymmetry. By transforming personal experiences into objective facts, ALAMES claims to provide heuristic resources for the emancipatory goals of social struggles currently developing in Latin America. The social medicine 'natural attitude' conceives health and disease not merely as the status resulting

from ill-conditions in society (as the 'risk factor' narrative of biomedicine would have it), but as a process historically determined by the economic, political and cultural phenomena. Health and disease are, therefore, the natural result of status asymmetries, political interests, ideological clashes and social injustices that unfold in a historical and situated trajectory specific to capitalism in the region.

To tackle health and diseases, ALAMES advocates for a thorough understanding of market-driven oppression, domination, and suffering underlying health phenomena that popular movements and social protests make evident. The notion of 'processes determining health', Casallas concluded, is the core argument of the social medicine approach to health causation found in the concepts and models that this chapter explores. Specifically, the chapter focuses on the social medicine critique of the *Hegemonic Medical Model*, the counterhegemony constructed by the collective health movement, and the social determination model the collective follows. The epistemological basis of ALAMES unveils how social medicine construes capitalism as the key operator and driving force of dominant medical practices, the overt 'medicalisation' of life, and the fragmentation of social determinants of health. In so doing, how social medicine imagines both the capitalist causation model of health is unpacked, based on the 'risk factors' thesis, and organisation's intellectual response to biomedicine.

The first section of the chapter unveils the social medicine critique of the capitalist biomedical framework, also known as the *Hegemonic Medical Model.* The insights of three pioneering authors are considered: Eduardo L. *Menéndez*, Susana Belmartino and Alberto Vasco Uribe. Early in the development of the ALAMES collective, these academics prepared the ground for the critique of biomedicine by explicating the exclusivism of this generalising epistemology, arguing that biomedicine rendered invisible other critical and situated approaches to the causation of population health, through the process I framed as 'epistemic injustice' (borrowing from feminist scholarship). This critique explores the link between biomedicine and the capitalist apparatus according to ALAMES members, subordinating medical practices to the financial goals of the health market. The social medicine thought style also extends the critique towards the linear causation of the so-called 'risk factor paradigm', which grounds the rationality of contemporary epidemiological studies. Lastly, the implications of the collective health critique on the social determinants of health scholarship will be explored.

The second section critically analyses the response from the social medicine collective to the *Hegemonic Medical Model,* starting with a contextual analysis of biomedicine and then proposing a 'counterhegemonic' approach to health and disease in the Social Determination model. ALAMES focused on the historical nature of population health and disease – how current health inequities resulted from the social trajectory of a specific context. Deriving from Marxist historical materialism, social medicine authors drew conclusions about the integration of epistemologies, the subsumption of social systems, and the limits between 'the biological' and 'the social.' The Social Determination model constructs the epistemological framework through which the collective health thought style evaluates westerns societies, and organizes the reasoning of health and society in academic research. Lastly, the model breaks down the processes in both the down-stream and up-stream social system, yielding different levels of determination that make evident capitalism as both a socio-economic model organising society, and the bundle of principles, values and objectives that shape individual and communal life (the capitalist ethos). The chapter brings together other concepts in the ALAMES epistemological framework, including social reproduction and production, the dialectical movement, and the general-particular-singular domains of determination.

II. THE ALAMES CRITIQUE OF THE 'CAPITALIST' MODEL:

a) THE HEGEMONIC MEDICAL MODEL:

"The hegemonic medical model attempts the ideological exclusion of other alternative health models. The efforts are manifested through the appropriation and transformation of the alternatives, resulting in a simpler epistemological thesis that complements the core features of the hegemony…the expansion of the hegemonic medical model generates an epistemological crisis normally resolved through the integration of other models - rather than the confrontation or ideological clash with contradicting alternatives" (Menendez, 1983 in 1992:98).

Eduardo L. *Menéndez*, Susana Belmartino and Alberto Vasco Uribe were three Latin American social medicine scholars who inspired the ALAMES critique of the *Hegemonic Medical Model* (Stolkiner

and Ardila, 2012; Casallas, 2017). The conceptualisation of the model has circulated ALAMES at least since the first ALAMES International Conference in 1987 at Medellin, Colombia. The model is conceived as the pinnacle of biomedical exclusivism, that is, the biomedical favouring of natural sciences at the expense of evidence-claims from other disciplines in the production of health knowledge. The biomedical hegemony, according to ALAMES members, precludes health epistemology from acquiring a fuller picture of the situatedness of the health and disease process – skewing research and action on population wellbeing towards approaches of limited efficacy. The critique of the *Hegemonic Medical Model* is informed by the experiences and professional development of the social medicine collective.

Menéndez, an Argentinian medical anthropologist and professor at the Centre for Research and Advanced Studies in Social Anthropology in Mexico City, was born into a working-class immigrant family that escaped the Spanish Franco regime in the 1930s. He was strongly influenced in his youth by communist ideas from his father's affiliation with the local socialist party, and his participation in the first wave of the populist governments in 1940s Argentina (Menéndez, 2012a, b). Menéndez completed his studies in social anthropology, centring on Marxist materialism and Gramsci's diversification of ideology to integrate culture into analyses of society. The author said: "I began to discover and accept that, parallel to questioning the social system, I was also contributing to the reproduction of the dominant order through my conduct, daily tasks and social relationships" (2012b:116) – a perspective which framed his later thoughts on the *Hegemonic Medical Model.* For Menéndez, Marxist critical theory enabled self-awareness regarding the reproduction of the oppressive standing system, emerging from the generation of communal habits or 'modes of living' which progressively become normalised in society. The 'social reproduction' of capitalism, as he framed it, transforms political ideology into everyday culture by converting rhetoric and moral representations into common-sense, practices, beliefs, and traditions. His methodology, later assimilated into the ALAMES epistemological framework, explored the multiple ways in which a social system is reproduced in the habits of everyday life.

He explained that early anthropological research in the region was devoted to the study of native practices in Latin America, and was instrumental in the acculturation of local knowledge, as well as the imposition of the *Hegemonic Medical Model* as the universalising approach to health (2012a). Anthropological 'colonial studies' typically explored ethnographically endemic diseases, like Yellow

Fever, Malaria and Cholera, aiming to enhance labour productivity in oil extraction territories, and industrial deforestation. For him, the strengthening of Latin American medical anthropology was linked to the growth of transnational corporations that used technical approaches of preventive medicine to disregard contextual particularities, and systematise one-size-fits-all health strategies (which proved efficient for their financial goals). Consequently, Menéndez sought different approaches to health-related social science in the late 1970s, connecting with the Latin American social medicine network through Argentinian colleagues who utilized the collective as an alternative to the biomedical perspective. Menéndez recognised the richness of the collective health thought style for emancipatory and revolutionary efforts in Latin America. However, he never adhered to the ALAMES collective, as he saw no differentiation between social medicine, and the structuralist strand of medical anthropology which he criticised. According to him, medical anthropology, biomedicine and collective health – though seemly speaking comprehensively about health and disease – ultimately study, think and act in terms of disease alone.

Menéndez experienced state terrorism in late-1970s Argentina, perpetrated by the CIA-supported military coup, termed *Proceso de Reorganization Nacional* (National Process of Reorganization). The new authoritarian regime established a neoliberal state, led by the *Junta Militar* (Military Junta). Menéndez's research encountered several obstacles, as various anthropology departments were closed during the repression and persecution of the *Plan Condor,* endangering the lives of staff. He observed: "It is impossible to explain with words what happened and how we felt during this time – intellectuals were persecuted and slaughtered not merely with impunity but as exemplary cases of the consequences of our thinking" (2012b:124). During the military coup, Menéndez helped to establish the Anthropology Department at the public Universidad del Mar de la Plata in Argentina. As Menéndez explained, the city was raided by the extreme right-wing clan *Concentracion Nationalista Universitaria* (University Nationalist Concentration), responsible for most forced disappearances and murders in the so-called 'blood-bath of La Plata'. He himself was subject to multiple threats, and survived several murder attempts, which led to his exile in Mexico where he joined the *Escuela Nacional de Salud Publica* (Public Health National School), continuing interdisciplinary work, and developing the concept of the *Hegemonic Medical Model*.

According to Menéndez, this model constructs a way of reasoning reality, based on biomedical exclusivism and the dismissal of other forms of health epistemology that do not arise from the

technical sphere of scientific empiricism. Similar to the analysis of 'medicalisation' (Conrad and Potter, 2000; Rose, 2010; Rosenberg, 2015), Menendez argued that the capitalist biomedical approach conceives life under the singular gaze of positivist knowledge, making biological research the sole standard upon which truth is constructed in health. In so doing, the *Hegemonic Medical Model* overlooks and disregards other processes impacting population health at the economic, political and cultural level, including the collective practices of self-care occurring within communities on the ground. Menéndez wrote: "All societies create conceptions and practices in health which precede the considerations of any healer - including the biomedical ones" (2012bb:340). As a social medicine academic and anthropologist, he has researched the multiple forms of prevention that naturally emerge from the modes of life within communities, contrasting the technocratic approaches from clinical medicine often alien to local populations. To him, preventive care is a structural element of quotidian living, decisive for the social and biological reproduction of communities, which people learn through socialisation and collective engagement. Preventive health is not, therefore, the expert recommendations emerging from contemporary healthcare institutions.

The *Hegemonic Medical Model* precludes comprehension of underlying social processes, giving predominance to vertical healthcare approaches that disrupt the continuity of situated epistemologies. To Menéndez, the biomedical model represents a form of universalising knowledge that is "ahistorical, asocial, individualistic and frequently focused on pragmatic practices" (Menéndez, 1992:102). It was not that the capitalist model neglected self-care altogether, but that the model conceptualised it in terms of individual conduct, constructed through medical education and behavioralist interventions. In biomedicine, self-care becomes a resource of survival that must be learned from foreign expertise, rather than from the socialisation within the community (as conceived by Menendez's anthropology). In this way, biomedicine assumed responsibility for teaching 'true' preventive care that replaces the inferior local knowledge. The *Hegemonic Medical Model* therefore excludes particularised health epistemologies through the appropriation of naturally-occurring phenomena in social life (self-care), reframed in its own terms (individual behaviour), and made functional for the objectives of biomedicine (self-care as state-sanctioned preventive medicine) (Menendez, 1988, 2020).

Carlos Bloch and Mario Testa, public health professionals and pioneering members of the social medicine network, elaborated on Menéndez's work. These authors argued that post-1960s Latin American public health settled 'barriers' between the healthcare sector and other domains in society, limiting "the shift in our understanding of the health and disease process" (1987 in Rojas, 2009:192) beyond healthcare alone. The *Hegemonic Medical Model,* Bloch and Testa continued, emerged as the epistemological framework that justified exclusionary practices in the health sciences, validating a disciplinary distinction between biological medicine and other sciences. In this model, medicine focuses exclusively on the biological processes of the body, the mechanisms involved in diseases, and the various conditions that trigger illnesses. The *'biologicismo de la medicina*' (medical *biologicism*) therefore treats social processes as second-class knowledge, constructing a false sense of impartiality and objectivity in knowledge-claims by claiming autonomy from the values, principles and common-sense of everyday life. Bloch and Testa presented the *Hegemonic Medical Model* as an arbitrary displacement of any other health epistemology outside the so-called hard sciences, neglecting, disregarding and rendering invisible the critical social scientific approaches of 1970s Latin American social medicine.

As a means of excluding communal practices in health and rejecting certain types of social science, the way ALAMES conceives the *Hegemonic Medical Model* constitutes a version of 'epistemic injustice' in the sociology of health. 'Epistemic injustice' comes from feminist social epistemology literature (Fricker, 2007; Medina, 2013; Kidd et al., 2017; Grasswick, 2018), indicating how certain dominant forms of knowledge-formation generate oppressive norms and practices against alternative epistemologies. For feminist authors, epistemic injustice is used to understand how knowledge practices are shaped by the relations of gender, and whether gender should play a role in 'good' knowing. Nevertheless, the analysis of gender in knowledge "is generalisable to an interest in how power relations play out epistemologically, especially in systematic relations of power" (Grasswick, 2018:2) – including the asymmetries between universalising epistemologies like biomedicine, and local knowledge or situated approaches like Latin American social medicine.

Provided the *Hegemonic Medical Model* constitutes the imposition of a way of thinking through developmentalist policy reforms in Latin America, ALAMES presented the capitalist biomedicine as systematic oppression predominantly manifested within health epistemology, medical discourses, state institutions and clinical practices. The 'hegemonic' nature of biomedicine configured epistemic

injustice in Latin America as a type of power politics that creates a value-hierarchy in health-knowledge, based on principles like objectivity, neutrality and impartiality. Insofar as biomedicine is supposedly value-free, decontextualised, trans-historical, and unbiased, any epistemology that falls outside of biomedical coordinates is rendered unworthy, inferior and inadequate by the standards of objectivity (Code 1991, 2006; Daukas 2006, 2011). Local communal practices and situated critical perspectives, like the ones espoused by ALAMES, are therefore marginalised, demeaned, and silenced.

According to Menéndez, the down-grade given to situated epistemologies (like ALAMES) by the *Hegemonic Medical Model* is based on a benchmark of social credibility that holds negative prejudices against socialist theories and communist ideologies – particularly in the context of twentieth-century Latin America. Following a wave of right-wing dictatorships, state violence, and persecution of socialist leaders explored in the last chapter, Latin American history crafted a milieu of cultural predisposition against approaches deemed as Marxist. The *Hegemonic Medical Model* undermined social medicine in its capacity to generate evidence and knowledge, by perpetuating stigmatisation against historical materialism, precluding its use in the majority of medical programmes across the continent. Consequently, in order to develop Latin American social medicine research in local academia, many ALAMES members like Mario Hernandez, Ana Lucia Casallas and Saul Franco, have worked under the disguise of 'public health' - lest their approach is rendered unworthy. Only few programmes across Latin America allow the integration of the collective health approach. These include the Universidad Andina Simon Bolivar in Ecuador, Universidad de Lanus in Argentina, the CEBES in Brazil, and UAM-X Mexico, amongst others. Predispositions against the collective health thought style, Menéndez concluded, disable multiple epistemic tools social medicine has developed to facilitate the expression of experiences by ill-equipped social movements in health. The *Hegemonic Medical Model* refuses to engage with the frameworks that challenged its ability to reproduce biomedical dominance, maintaining various levels of exclusion, oppression and injustice towards the ALAMES thought style to this day.

Lastly, Menéndez argued that the *Hegemonic Medical Model* has been functional to contemporary capitalism by generating dependency on pharmaceuticals and health technologies to address medical concerns, under the assumption that biomedicine is the only adequate approach to health. According to Menéndez (1988, 1992), the capitalist biomedical model thrived on the knowledge gap

between the physician and the patient, forcing the subordination of the latter to the directives of the former. The capitalist enterprise seized this asymmetry from the 1960s onwards, by partnering with research centres and university institutes to expand biomedical evidence-claims, and to strengthen the market approach to health. In so doing, capitalism captured biomedical research to benefit its epistemological authority, and thereby increase profits. The strategy arguably peaked in the 1980s through the exponential growth of market principles in healthcare, and the wave of international neoliberal reforms, including the introduction of an insurance industry and drug patency laws. Though Menéndez recognised that biomedicine was efficient in reducing the morbimortality of prevalent disease, he also noted that the capitalist biomedical model has proven to increase iatrogenesis, worsen financial crises, and disconnect healthcare services from population needs. Given the aggregation of epistemic injustices, for-profit drives, institutional oppression and market dependency, Menéndez wrote: "We are progressively witnessing a consensus on the 'crisis' of the *Hegemonic Medical Model* that must be acknowledged by the state, as the foundational organism of society" (1992:100). Susana Belmartino added:

> *"The hegemonic medical model…emerges from the necessity to tackle diseases in organs and systems, while systematically neglecting the individual and society as an integral part of the process. The model encourages medical practices towards specialisation, fragmentation of knowledge and isolation of the human being. The crisis of the hegemonic medical model consists of the artificial removal of health and disease from the processes of society in which the suffering individual is embedded" (Belmartino, 1987:198).*

Susana Belmartino is a professor of history and former director of the Masters in Public Health at the Centre for Interdisciplinary Studies of the public Universidad Nacional Del Rosario (UNR), Argentina. She is the former editor of the journal *Cuadernos Medico-Sociales* (that has extensively published papers from the ALAMES collective), and founding member of ALAMES at Ouro Preto in 1984. Her career began in the late 1960s at the UNR, which was significantly disrupted by the military coup and fascist dictatorship of General Ongania in 1966, also known as the Argentinian Revolution (Belmartino, 2015a). She fled to France to complete a doctoral degree, returning to Argentina in the 1970s to take part in the re-establishment of university departments during the brief democratic epoch of the Perón administration. In 1975, however, the establishment of the *Junta Militar* re-introduced the regime of terror and slaughter of socialist intellectuals and leaders, enacting neoliberal structural reforms, the expansion of international debt, and state violence

through the *Plan Condor*. Belmartino ceased her academic activities, and took refuge working different jobs locally.

Shortly after in 1978, and by coincidence, she met Carlo Bloch, a member of the growing Latin American social medicine network, who at the time "was a syndicalist leader attempting to organise a research group for the Medical Association of Rosario…it was work involving research in health policy and history of public health" (Belmartino, 2015a; see also Spinelli et al., 2017). Belmartino joined the recently-established *Centro de Estudio Sanitarios y Sociales* (Centre for Sanitary and Social Studies or CESS), the founding hub of the journal *Cuadernos Medico-Sociales*. The regime considered the history of public health a 'neutral' topic, so she was able to develop a critical approach towards biomedicine, and the *Hegemonic Medical Model*. Through Argentinean colleagues, including Juan Cesar García, Mario Testa, Hugo Mercer and José Carlos Escudero, Belmartino joined the Latin American social medicine network to co-found ALAMES in 1984.

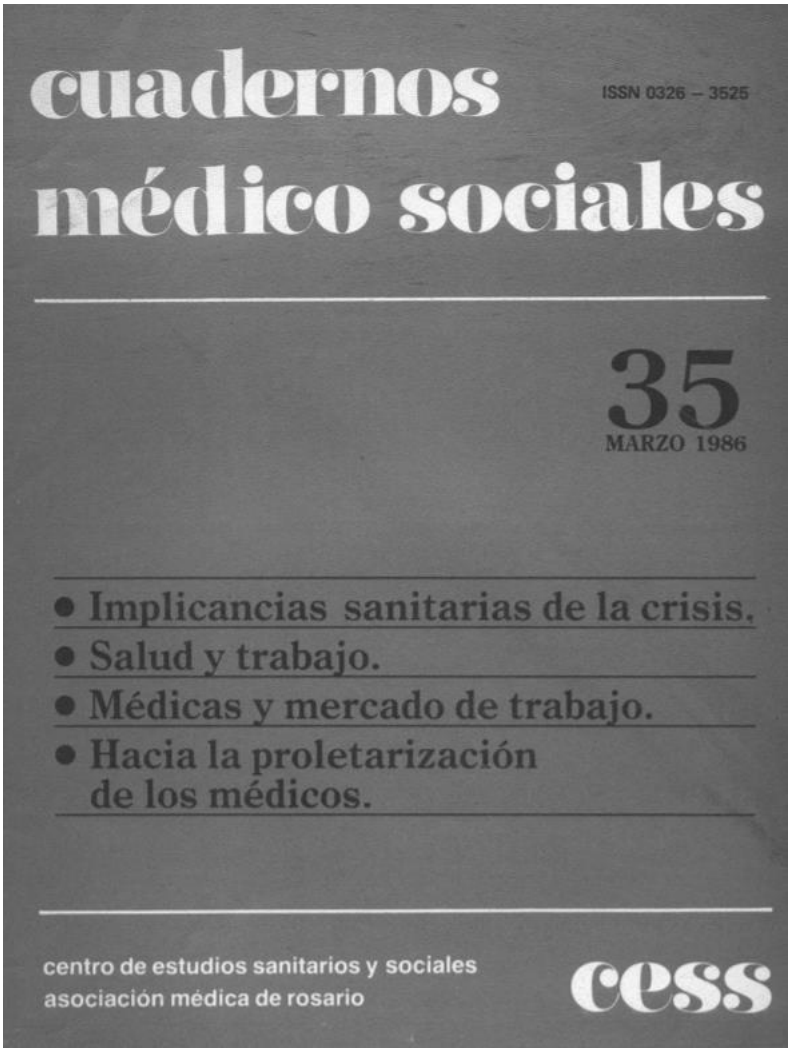

Image 4.1 Cover of the Journal Cuadernos Medico-Sociales Volume 35 published in 1985. The Journal was edited by Susana Belmartino and Carlos Bloch during the 1980s. Themes of this volume: Sanitary implications of the crisis, Health and Labour, Medicine and the Market, the Proletarisation of Medics. Source: Spinelli et al., 2017

For Belmartino, the *Hegemonic Medical Model* conceptualises illnesses as punctual events that attack the individual at a specific time and place, the causes of which may be established through careful retrospective inquiries. This mode of reasoning health 'forgets' that individuals exist within a social milieu that conditions and determines the causes of disease. "(…) The model overlooks the fact that health and disease are not isolated phenomena … but belongs within larger processes that aggregate other dimensions like ethical values and cultural traditions" (Belmartino, 1987:198). Similar to Menéndez, Belmartino argued that the success of biomedicine lies in its clinical effectiveness at containing and relieving diseases. This recognition created a tension within the ALAMES collective regarding the utility of the *Hegemonic Medical Model* vis-à-vis its exclusionary stance towards critical social sciences on health. Given that rejecting the biomedical paradigm was

not an option – and yet transformation was warranted - both Menéndez and Belmartino responded to the paradox by focusing on critical analysis of two issues.

First, Belmartino explained that the *Hegemonic Medical Model* relied on biomedicine as the 'most rational' way of conceiving health, enabling the standardisation of medical practices and attempting universal knowledge about bodily processes. She agreed with Menéndez that the capitalist model was not merely dominant by subordinating situated epistemologies, but also that it appropriated alternatives, aligning all rationales and practices to itself. Biomedicine relies on individualist and biological perspectives to isolate disease factors, generating effective clinical interventions based on the specialisation of health professionals relative to fragmented elements. Through fragmenting knowledge, the *Hegemonic Medical Model* elaborated on 'technocratic medical practices' in which interventions were reduced to quantifiable measurements that facilitate the optimisation of care, both at the clinical and financial level (more efficiency, more productivity). Consequently, technocratic interventions from biomedicine acquired a monopoly of knowledge, deepening the asymmetries between health epistemologies, under the assumption that technocracy was more reliable and accurate. Belmartino wrote: "The technocratic nature of the *Hegemonic Medical Model* creates a sense of superiority of the physician over the patient, constituting subordination of the former to the latter, transforming the medical doctor into the all-solving agent" (1987:198). For the author, the exclusion of the individual perspective and the communal knowledge from medical practices resembled the Marxist alienation critique of workers from their labour. Belmartino suggested that the technique took precedence over the subject, preventing individuals and communities from acting on their circumstances, unless directive by the biomedical approach. Thus, the *Hegemonic Medical Model* depoliticised life, by rendering reality a matter of biological science, reducing health to the material experiences of body physiology and pathology.

Second, Belmartino focused on the market logic of the *Hegemonic Medical Model* to counteract the exclusive and superior value granted to the biomedical paradigm. She argued that the dominance of individualist, biologist, ahistorical and acontextual medical practices resulted from the general acceptance that they were the way *par excellence* for resolving medical problems in health. Though clinical efficacy was a fundamental contributing factor, Belmartino argued that the consolidation of the model as the predominant western approach to health comes from the commodification of healthcare services and resources, generated through the development of the medical sciences.

From the Second World War, the advent of healthcare insurance systems to pool and redistribute resources through intermediaries enabled the rise and strengthening of the health market, reinforcing the treatment of population well-being as a matter of healthcare services and technologies. Besides preventing communities from intervening in the management of their care, the capitalist perspective directed concerns about population health away from the economic, political and cultural dimensions of society and towards an emphasis on medical resources that produce profit. The phenomenon is documented elsewhere as the 'pharmaceuticalisation of public health' (Sismondo and Greene, 2015; Davis, 2015; Thomann, 2018), and has become the favourable condition for pharmaceutical corporations and interest groups to abuse drug prices, manipulate patency laws and exploit research data, amongst other consequences. "The development of biomedicine as practices generating great wealth," Belmartino added, "enabled the medical practices to become an essential sphere of capital valorisation" (1987:201). The *Hegemonic Medical Model*, therefore, reproduced capitalism not merely as a socioeconomic model that organises society, but as a way of understanding the relationship between health and society.

b) THE SOCIAL DETERMINANTS OF HEALTH:

Belmartino has also questioned the clinical effectiveness of the biomedical approach as, statistically, the approach has eradicated some infectious disease; but it has been less successful at treating chronic diseases associated with contemporary capitalist lifestyles. Other concerns, such as ageing, long-term care and incurable conditions, require a framework that interprets health as an ongoing dynamic, intertwined with societal processes that, according to Belmartino, the capitalist model is incapable of comprehending. In similar terms, Alberto Vasco Uribe critically analysed the biomedical causation model of health, as he wrote:

> *"Biomedicine relies on the idea of disease as the loss of an original state specific to the human being and natural in itself, conceptualising the causes of illnesses as an externality of a specific origin … In other words, health as the absence of disease places the cause of illness outside of the person, framing the content of external uni-causality that is an integral part of the dominant medical thinking today. By relying on such a causative explanation, dominant medicine eliminates other interpretations and forms of thinking" (Vasco Uribe, 1987).*

For Vasco Uribe, the *Hegemonic Medical Model* defined health as the absence of disease, and relied on the linear North American functionalist approach to causation in health. The linear approach consists of explaining the occurrence of illnesses as emerging from one factor (proximal causes), or multiple-layered factors (distal causes) to produce the disease. Similar to the analysis of contemporary biomedical evidence in the philosophy of science (Illari, 2011a, b; Russo and Williamson, 2007; Illari and Russo, 2014), he explained that the unicausal/multicausal paradigm in the capitalist model isolates variables presumably correlated with ill-conditions, and proves the causal association by (i) demonstrating a causal link through statistical data, (ii) unveiling the material mechanisms, a cascade of events or pathophysiology through which the causative agent or risk factor and the disease are connected, or (iii) a combination of both types of evidence within the same thought style.

The *Hegemonic Medical Model* linearly connects cause and effect for analytical purposes, neglecting the context and its processes implicated in health and disease. For Vasco Uribe, the reductionism of the biomedical model in making life an issue of linear connection represents a power-move to systematically deny the situatedness of and critical narratives emerging from oppressed, marginalised and discriminated positions. Such is the case of Lalonde's model of health (1974), which aggregated causality from the environment, genetics, healthcare services and individual lifestyles as isolated yet connected variables to explain the emergence of diseases – leaving no heuristic resources to convey how class struggles or racism impact health. The linear causality of biomedicine also explained the prestige and broad acceptance that contemporary biomedical practices enjoy in most western societies. Though the model has contributed to understandings of health and disease, Vasco Uribe highlighted that these approaches also meet theoretical and methodological obstacles that demonstrate the limitations of their reasoning, including the inadequacy of neglecting the unavoidable complexity of health phenomena found in contextual particularities.

Vasco Uribe argued that the capitalist model assumes that ill-conditions can have an unequivocal and precise diagnosis. Through linear causation, biomedicine posits specificity between the causal explanation and the actual disease, enabling the construction of a medical taxonomy and standards of care. In reality, he stated, the limited replicability of contemporary taxonomies unveils the level of uncertainty on which medical practices operate. Contemporary biomedical narratives on the

pathogenicity of Tuberculosis, for example, paradoxically rely on the evidence emerging from only a small fragment of the cases exposed to the bacteria. According to him, out of the total number of people exposed to the *Mycobacterium Tuberculosis*, a small proportion had some immunological reaction to the exposure, and an even smaller fraction developed the detectable disease. If lineal causation worked as the *Hegemonic Medical Model* suggests, then all cases of microbial exposure would lead to a diagnosis. However, Vasco Uribe concluded, contemporary medical practices extrapolate the natural history of the disease from exceptional cases rather than the predominant ones, yielding unrealistically universalising knowledge-claims. Simultaneously, the capitalist model neglects the multiple explanations associated with virulence to maintain the veracity of the linear approach, disregarding the impact of sanitary approaches such as housing, sewage, and ventilation, and the political obstacles that disable the realisation of sanitary material conditions. Similarly, Vasco Uribe pointed to a myriad of illnesses whose differential morbimortalities among populations with similar biometric characteristics have been inappropriately considered by the biomedical paradigm, that is to say, biomedicine ignored evidence about social inequalities of health. Obscuring other types of knowledge-claims that take social dynamics seriously further undermines the reliance of contemporary societies on the *Hegemonic Medical Model* as an all-encompassing explanation for health. The lack of specificity and accuracy in biomedicine, Vasco Uribe concluded, often makes interventions less than satisfactory and rather detrimental.

To Vasco Uribe, the linear approach is grounded in the western metanarrative of Christendom, a teleology that conceives humanity as fallen creatures seeking to return to their original state. Health as the absence of disease represented the struggle to return to the original state by reinforcing the idea of disease as emerging outside the body – an evil that must be 'tamed'. In grounding disease in such metanarrative, health epistemology defined health in absolute terms. According to the dominant capitalist model, the 'physiological' mechanisms in the body constitute the yardstick for normality and purity. Any variability from the norm implies pathology, deviance and aberration. Using such standards, Vasco Uribe argued, biomedicine effectively depoliticises the body, and reduces life to questions about science and biology alone. In contrast, bodily physiology conceived by the socio-medical paradigm "ceases to be a pre-established and static condition and becomes the product of adaptability in the organism" (Vasco Uribe, 1987). Latin American social medicine sought a comprehension of physiology that admits the possibilities of 'many physiologies,' which may be separate from the norm, and yet do not necessarily correspond to a pathology. According

to Vasco Uribe, the alternative to the *Hegemonic Medical Model* is an open-ended and malleable standard of health that integrates different epistemologies that more accurately grasp the dynamic and incommensurable nature of life and death (see also 1975, 1977, 1978).

Following the underlying metanarrative of biomedicine, Vasco Uribe explained that the *Hegemonic Medical Model* treats social factors as 'external' and 'foreign' to biological processes, fragmenting and isolating the social conditions associated with health and disease. Contrasting Menendez and Belmartino above, the biomedical approach for Vasco Uribe does not ignore the social basis of health and disease, but interprets it as causal factors that are static and measurable through quantitative means. Vasco Uribe objected that, when reality is fragmented into multiple risk factors, action upon health becomes multiple efforts on isolated risk factors only, rather than any transformation of the processes determining the emergence of risk factors in the first place. The impacts of social factors associated with health is therefore 'superficial' and 'minimal,' mismatching the actual claims and requirements that matter at the local level, and questioning the utility of population-level interventions (1978, 1986). Breilh added: "Medical researchers abandoned the focus on general relationships between biology, politics and economics – to devote efforts to the mechanics of 'internal body' vs 'external environment'" (2003a:199). According to him, the history of clinical medicine unveiled a tendency to simplify the social processes that impacted health as a series of factors, variables or conditions to fit a cause-effect paradigm. Also labelled the 'risk factor paradigm', and commonly found in health epidemiology, the simplification made by the capitalist model attempted to reduce the complexity of health into a more manageable object of study for intervention. "Thus," Breilh concluded, "reductionism and the formal constitution of the scientific approach were carved into the ethos of epidemiology, vanishing the link between epidemiological phenomena with the general processes in society" (2003a:200).

Rather than contributing to the construction of a fuller picture of reality, Breilh argued that the risk factor paradigm became the totalising standard of accurate research, producing the so-called 'taming of health' (Breilh, 2019a). In his view, the 'taming of health' stemmed from the simplification of health phenomena to mechanisms that could be neatly separated between domains, diluting the efforts of nineteenth-century social medicine scholars that sought to unveil the relationship between the political-economic conditions of society, and the biological processes of the body. In so doing, health research became a bundle of knowledge-claims that, through removing situated

values and background assumptions, could be generalised to populations that have no relationship or closeness to the original context where the knowledge was retrieved from. Breilh explained that the 'taming of health' developed from the intellectual efforts of academics, like Henry Welch at the Pathology and Physiology Department of the Johns Hopkins University School of Public Health in the early twentieth-century. US reductionism followed the thriving experimental biology principles of the German sciences, applying the most rigorous statistical modelling and biometrical principles in health research. In time, the approach was strengthened through the philanthrocapitalist ventures of the Rockefeller Foundation, and the pedagogical systematisation of the Flexner Report. According to Breilh, mathematical methods initially played a subordinate role in the analysis of diseases, only later becoming the focus of research as "(…) the concept of 'risk' replaced all understanding of the context" (2003a:198).

Breilh followed the progression of the risk factor paradigm into the emergence of the Social Determinants of Health literature (SDH). As he saw it, the risk factor paradigm in the 1930s acquired a central role in understanding the social basis of health, due to the impact of the Great Depression on the vulnerability of individuals and exposure to dire conditions. Rather than a societal analysis, research primarily emphasised 'risk' as an individual level concern, made evident in behaviours and lifestyle habits. Consequently, epistemological efforts simply replicated the reductionism of the natural health sciences to the study of society, through statistical associations between social factors and health. After the Second World War, the concept of 'risk factor' became an integral part of the biomedical approach, which likewise integrated epidemiology in understanding the relationship between health and society (Breilh, 2003a:198-199). The emphasis on the quantification of techniques, and the emergence of cost containment analysis by the capitalist co-optation of health research, further elevated the risk factor paradigm in the health sciences throughout the 1960s and 1970s. The Social Determinants of Health were consolidated from the 1980s onwards, based on the benchmark of the risk factor above.

Breilh considers that evidence on the Social Determinants of Health developed into social epidemiology as a discipline by following the 'risk factor paradigm' to create an illusory sense of objectivity reflecting the linear causality between social variables and health outcomes. The ALAMES collective more broadly criticises SDH for "failing to capture that individual biology is subsumed in the social order" – a subsumption in itself socially and historically determined (Abadia-Barrero and

Martinez-Parra, 2016:1231). In so doing, Breilh added, biomedical epistemology disregarded the complexity of the health phenomena, the structural processes linked to diseases, and the dynamics of situated processes that determine the distribution of population health. Social epidemiology acts on each factor in isolation, with a myriad of fragmented programmes or policies that remain disjoined from the political actors of social change. "When you see the world as factors," Breilh concluded, "then you act over factors alone…which might produce some changes in isolated elements but does not change society as a whole" (2018b). For him, the production of knowledge in health must extend beyond epidemiological data, such as the rate of infant mortality or the proportion of maternal survival, and embrace an emancipatory project that not only impacts the 'peak-of-the-iceberg' indicators, but also transforms the underlying processes that sustain the ethos of society. To this end, research cannot remain limited to characterising causal links between social factors and health, but must analyse political economy, social history, and underlying ethical principles determining the broader context. In other words, Breilh said, the emancipatory research advocated by Latin American social medicine required the articulation of clinical medicine, biological sciences and epidemiology, with critical sociology, anthropology, history and medical humanities.

Through the last decade, the ALAMES network has published multiple pieces critically analysing the Social Determinants of Health. Most of the content follows the directives of Breilh described above, highlighting the superficiality of the research in merely unveiling social factors but neither demystifying, nor destabilising the social processes and historical trajectories involved in the emergence of the factors (ALAMES, 2008; Hernandez, 2013; Morales and Eslava, 2014; Abadia-Barrero and Martinez-Parra, 2017; Eslava, 2017; Marques et al., 2018; Cardona-Arias et al., 2019). Though both the ALAMES epistemology, and the Social Determinants of Health recognise the relevance of the social sphere interacting with the bodily processes of individuals, "the differences between the approaches emerge at the level of the ontology, epistemology, and praxeology" (Morales et al., 2013:23; see also Hernandez, 2008). Morales and colleagues explained that the ALAMES view of the Social Determinants of Health is best understood through the following three arguments.

First, the SDH understands society as an aggregation of individuals, making it possible to reduce societal processes to individual dynamics within groups. The group and societal levels of determination in health are collapsed to fit the boundaries of person-to-person interactions, which

the SDH conceptualises under the term 'socioeconomic status.' According to Morales et al. (2013), socioeconomic status places the person at a particular level of vulnerability within the morbimortality of the population according to income, occupation and level of education. However, this move simultaneously makes invisible the power relations, structural injustices or systematic oppression that underlie the socioeconomic hierarchy of the analysis. So, while the SDH flags structural causation, the epidemiological research casts health inequities within and between countries as products of risk factors and exposures that are empirically measurable. The central concern remains at the individual level, suggesting actions that never reach the structural transformation of society, and falling short of the revolutionary objectives promoted by Latin American social medicine. Whether this is true or not is not the objective of the present research. The point is to display how adamant, radical and strict the thought style is in exhibiting the exclusivism of biomedicine to individualised health, privatised healthcare, risk factor paradigm. The interesting tension to highlight is how the antagonism to biomedicine sponsored by ALAMES occurs within a thought collective whose fundamental framework is meant to be inclusive of various health epistemologies (including biomedicine). This feature will be developed further in the next section.

Addressing the strategies found in the UN Commission on Social Determinants of Health report (2008), Martinez highlighted: "All the propositions for change are devised within the same framework of the standing conditions, that is to say, within the limits of the current model of social organisation which do not enable deep solutions" (2008:37). For Martinez, without transcending the coordinates of the current hegemony, no possible transformation of society may be achieved. The SDH remains within the epistemic coordinates of the *Hegemonic Medical Model* through its superficial approximation of health inequities, merely attenuating the consequences of the standing power relations – but never addressing root causes.

Second, the SDH sustains biomedical functionalism by advocating standards of statistical normality through which any variance from the mean is deemed a deviation from the norm. The standards become normative benchmarks for judging society, granting value to collectives, and positioning epistemologies within a pre-established hierarchy that appears unquestionable and inevitable. Consequently, "all conditions of life are perceived as factors without a history" (Morales et al., 2013:800), which the individual acquires through his/her personal trajectory. The approach avoids unearthing the influence of context-specific circumstances upon the factors that determine

individual vulnerability (see also Eibenschutz et al., 2011). Abadia-Barrero and Martinez-Parra explained that the ALAMES theoretical work emerged precisely out of the critique to modern health epistemology “principally for its emphasis on developing ahistorical schemes such as those responding to paradigms of risk and causality” (2017:1229). Marques et al. expanded on the social medicine critique, stating that a-contextual health science morphed into ‘laboratory practices’ intended to present things ‘as they are,’ while taking historical and genealogical accounts of the political, economic and cultural aspects of health as a 'hindrance to scientific development' (2018:355-356). The social stratification of a person in terms of attributes, such as education, occupation, income and social cohesion within groups is detached from the historical trajectory of the context in which the individual is embedded, giving a false notion that life conditions are static and naturally given. The limitations of the SDH paradigm, Morales and colleagues concluded, trump the emancipatory efforts of popular strikes and social movements to radically transform society.

Third, resulting from the features above, the SDH gives paramount importance to state actions, public policies and national programmes. The emphasis is on top-down approaches that primarily devotes efforts to the public administration of resources, and socioeconomic agreements between specific segments of the population – mostly powerful groups at the cost of the working-class and most vulnerable. The SDH "does not question the structural basis of health inequities that are associated with the model of capitalist accumulation" (Morales et al., 2013:801). According to these authors, the neglect of the economic, political and social forces determining health perpetrated by the SDH links with the underlying liberal notion of distributive justice, which emphasises individual responsibility to determine what is owed to everyone in society. In order to access state benefits, vulnerable sectors of society must 'play the role of victims', disregarding scholarly accounts that point at the arbitrary reasons for the emergence of standing health inequities including the so-called 'triple inequities' (labour exploitation, gender subjugation, and racism in Breilh, 2003a, c). The heritage of colonialism, the oppression of capitalist dictatorships, and the injustices of power asymmetries typical of twentieth-century Latin America are systematically and institutionally neglected or rendered invisible. For the SDH, Morales and colleagues explained, contemporary western societies provide a high degree of liberty and opportunities for all such that "health inequalities are not intrinsically problematic since the inequalities that are the result of free choice are acceptable and just" (idem). The role of state policies and interventions, therefore, is to

compensate or favour the re-establishment of individual liberties, placing social benefits under the scope of individual behaviouralism.

III. THE ALAMES EPISTEMOLOGICAL ALTERNATIVE:

a) COUNTERHEGEMONY IN ALAMES THOUGHT STYLE:

The previous section explored critiques of the *Hegemonic Medical Model* according to the collective health thought style, emphasising three main elements: epistemic injustice, capitalism as the key operator, and the challenges to the linear causation model in health. The segment also unveiled the connection of the capitalist model with the social determinants of health, and the risk factor paradigm predominant in contemporary health research. This second half of the chapter reconstructs the specificities of the social medicine epistemological framework in health, the health and disease process, and the social determination model. The reader will notice the use of capitalism as the reference point that directs the response from the collective health thought style, grounded in the ALAMES belief that the social order determining health and disease is fundamentally structured by market principles (Abadia-Barrero and Martinez-Parra, 2017:1231). Just as capitalism serves as the basis for the hegemonic biomedicine, the ALAMES response keeps capitalism as the key operator to construct a counterhegemony in health epistemology based on applying Marxist historical materialism to health.

For the sake of clarity, *hegemony* in the ALAMES collective refers to the alignment of all possible discourses in a particular context towards the values, principles and goals of a dominant ideology, so that reality appears to develop only within the epistemological coordinates of the hegemonic perspective. Although any given context yields ways of reasoning reality (or a particular element of reality) that antagonises the dominant perspective, hegemony expressly consists of the integration, suppression and/or transformation of all thought styles, including opposing ones (Samaja, 2004). This was the argument advanced by Menéndez regarding biomedicine and self-care, where the latter, though corresponding to the results of socialisation and independent from biomedical

knowledge, is integrated within the hierarchies of clinical medicine, and reframed as an issue of individual behaviour which biomedicine can optimise. Belmartino also illustrated this by pointing to traditional medicine, which, within the standards of validity accepted by the scientific medical community, may be integrated into the range of healthcare interventions as long as it provides evidence of clinical efficacy and cost-effectiveness. In both instances, practices of self-care and traditional medicine are integrated, suppressed and/or transformed according to the standards of validity and truth upheld by the *Hegemonic Medical Model*.

Aside from unveiling the particular ways in which ALAMES approached traditional public health, social medicine ideas about the *Hegemonic Medical Model* also revealed commitments to resistance and emancipation that underpin the collective. Catalina Eibenschutz, former ALAMES general coordinator and professor of sociology at UAM-X, stated: "The terrain of hegemony is one of ideological struggle which, though seemly determined by discourses of economic nature, has great importance for the aspirations of health movements to transform society" (1982 in Rojas, 2009:64). Quoting Gramsci, she defined hegemony as the capacity to direct and govern a society through a specific type of consensus, an overarching agreement where the dominant class resolves all conflicts, including those belonging to the dominated class. In so doing, the dominant class gives the appearance of vindicating social demands, but based strictly on its particular way of thinking and for the purposes of homogenising society towards its own set of political goals. Eibenschutz explained that the capitalist class constructed the *Hegemonic Medical Model* to dismantle social struggles, protests and manifestations against the socioeconomic model, by resolving immediate demands specific to healthcare needs. The capitalist states of 1980s Latin America built their hegemony through the provision of medical services, including expanded coverage, protection against catastrophic financial expenditure, and the strengthening of the healthcare insurance model. Once the ruling class had seemingly achieved this goal, the masses no longer pursue social transformation or abolition of structural injustices, appeased by changes to the most pressing and immediate problems. According to Eibenschutz, biomedicine is a type of hegemony that strengthens the dominance of the global market at the expense of egalitarian societies.

Edmundo Granda, co-founder of the Health Research and Advisory Centre with Jaime Breilh and an honorary member of ALAMES, claimed the success of clinical medicine over specific diseases enabled the rise and consolidation of the so-called *'enfermologia publica*' (public 'disease-ology'

(Granda, 2009a:188-189). The *enfermologia* corresponds to the expansion of individualised medical practices towards public health concerns, "(…) interpreting the collective as the sum of all individual diseases" (idem). According to Granda, the hegemony of clinical medicine implied the total devotion to the study and creation of methods, techniques and interventions relating to death and disease at the individual level alone, assigning particular roles in societal structures to reproduce the basis of its individualist ethos. While individual care thrived, institutionalised public health emerged to compensate for the blind spots of clinical medicine under the same logic of individualist, technical and mechanistic approaches. Consequently, Granda explained, "*enfermologia publica* situated risk and prevention of diseases in the positivist technologies managed by the state" (2009a:189), creating an entire apparatus that captured society's common sense through health institutions, medical guidelines, higher education, legal frameworks, professional commitments and civil society organisations, amongst others. In so doing, all alternatives to public health were subordinated to the *hegemony* of individualising healthcare.

Granda argued that the instrumental reasoning of the *enfermologia publica* cancelled out the possibility of studying the norms, principles, processes and dynamics underlying the hegemony, as well as preventing marginalised groups from questioning the *status quo*. In traditional public health, population health is achieved by tackling diseases through scientific technology and healthcare services, rendering approaches 'worthy' insofar as these reproduce the 'technical-normative' principles that make effective 'the power of the state' over the population (2009a:191). Such a hegemonic model, Granda continued, strips situated epistemologies from hermeneutic resources that help express their suffering and articulate emancipatory practices. Put differently, the *hegemony* of biomedicine is a system of domination that enables pockets of ignorance to maintain superiority over health epistemology, suppressing alternative ways of conceiving the relationship between health and society. As Granda concluded, to sustain the privileged status of *enfermologia*, the 'cognitive dysfunction' of the capitalist model must ignore or render invisible causal theorems that perform outside of the borders of the risk factor paradigm. Given the tendency of capitalist hegemony to misrepresent the world to support its dominance, Eibenschutz concluded: "Under no circumstance must we abandon the social struggle for emancipation – because, on top of guaranteeing the betterment in the conditions of living and health, emancipation allows the dominated population to re-appropriate political and class conscience" (*idem*). The collective health

thought style is therefore meant to represent an 'epistemological resistance' to biomedical exclusivism[5].

In response to the biomedical model, the ALAMES collective crafted the idea of social medicine 'counterhegemony.' The term refers to the same process of aligning all possible discourses towards a particular perspective – only now the perspective does not enjoy the status of dominance, but precisely aims to replace liberal, individualistic and capitalist medicine with the situated perspectives of marginalised standpoints (Galeano et al., 2011:286). During the late-1970s and early-1980s, Duarte-Nunes explained, the foundational economic system that grounded the *Hegemonic Medical Model* entered a crisis due to plummeting oil prices, escalating inflation, rising unemployment, and stagnant economic growth (1986). Academia questioned medical practices centring on the risk factor paradigm, alongside policies prioritising curative approaches, technological advancement, and hospital infrastructure. Elsewhere, Duarte-Nunes noted that the 'dissatisfaction' towards the growing deterioration of health conditions, and the inefficiency of analytical approaches, led to new analyses of the social aspects of health, constituting conditions for the rise of Latin American social medicine network (1983 in Rojas, 2009:133). For Duarte-Nunes, ALAMES labours towards a social medicine hegemony that trumps the exclusivism of the *Hegemonic Medical Model*, mainly through advocating an integrative health epistemology that combines multiple forms of knowledge-production rendered invisible by biomedicine. ALAMES 'counterhegemony' is presented therefore a more comprehensive approach to health, aggregating critical social sciences, including Marxist critical theory, medical anthropology, postcolonial studies, gender epistemologies, and the sociology of health.

For the ALAMES collective, the means through which 'counterhegemony' is achieved predominately focus on the conquest of medical education. Maria Isabel Rodriguez highlighted: "For me, this is the most critical aspect of the current state of affairs in Latin America: to achieve the transformation of the medical curriculum by alternative approaches in health epistemology" (2016). Rodriguez explained that the collective health thought style was successfully consolidated through the

[5] More details on the ALAMES critique of the hegemonic capitalist model can be found in Laurell (1978, 1982; Laurell et al., 1977), Samaja (1993, 1998, 2004), Almeida Filho (1989, 2001), Tambellini (1978), Ayres (1997), Victora and colleagues (1992) and Breilh (2003a). The work has also been explored by Duarte-Nunes (1986), Franco et al. (1991), and is summarised in the last chapter entitled *La Epidemiological Critica Latinoamericana* (Latin American Critical Epidemiology) in Breilh, 2010.

institutionalisation of postgraduate programmes across Latin America and the collective's incursion into international health organisations like PAHO in places like UAM-X and UERJ. However, the region's main medical programmes have kept the capitalist ethos that ALAMES struggles against intact at its core. The collective health movement has not yet transformed the dominant medical pedagogy beyond a few postgraduate programmes. The next challenge for the collective, Rodriguez concluded, is to cease being the alternative epistemology, and to become an integral part of the health epistemology taught in mainstream medical, nursing, and policy schools. On that note, Granda explained:

> *"The European social medicine movement imprinted a rich arsenal of doctrine and ideology, which was never integrated within the 'enfermologia publica.' Neither did Latin American social medicine movement manage to impact conventional public health despite the radical critique, the knowledge produced, and the innovative strategies of its theory…. Instead, the critique seems to have strengthened the preventivist paradigm by clarifying the technical success of its thinking" (2007 in Granda, 2009:188).*

Rather than presenting social medicine as an approach to replace dominant biomedicine, Granda distinctively advocated for the transformation of *public health* through the assimilation of social medicine and critical local epistemologies (see Betancourt, 2008). Granda pictured the possibility of reframing health epistemologies through the inclusion of knowledge-practices that matched the situated claims, needs and vindications of popular protests and social movements. The new '*salubrista'* (public health professional) is meant to mediate between population needs and institutionalised healthcare, contrasting the traditional approaches primarily invested on positivist calculations and the imposition of vertical approaches (Granda, 1999, 2000). "(Public health) cannot keep interpreting population and nature as objects," Granda continued, "but must necessarily comprehend them as subjects and propose new forms of dialogue corresponding to the new understanding" (2009a:9). Granda argued that Latin American social medicine has the responsibility of transforming public health, by expanding its ethos towards the multicultural and interdisciplinary dialogue that articulates other forms of knowledge, including those emerging from emancipatory groups and social struggles. For this purpose, Granda proposed reimagining methods that integrated the multiple hermeneutics of health, accounting for the nature of social structures and social processes impacting health, and crafting social practices and capacities beyond the power of the state and including collective habits and modes of living (2009a:192). In this way, the core of the

ALAMES 'counterhegemony' would be the diversity of health epistemologies within the constitution of a new medical corpus that integrates the struggles, concerns and knowledge from situated ways of thinking health and disease. The approach, nevertheless, is not shared by the collective homogeneously.

When addressing the political stance of social medicine, Breilh emphasised the commitment of ALAMES to radical societal change, a revolutionary objective based on the epistemological formulation of a 'meta-critique' or 'the ecologies of knowledge' (2018b; see also Santo, 2014). "A meta-critique," Breilh explained, "aggregates all the powerful tools that each one of the contemporary movements provides for the protection and emancipation of humanity" (*idem*). ALAMES 'counterhegemony,' therefore, represents not merely the juxtaposition of knowledge, but the 'integration' of evidence-claims into a health epistemology of multiple knowledge. The ALAMES approach is an interdisciplinary, intercultural and strategic science programme that provides social struggles with the epistemic resources that articulate not only academic knowledge, but also the 'knowledge of the people.'

Additionally, the integrative nature of Breilh's meta-critique diverges from contemporary tendencies to atomise social struggles, evident in the separate banners of the political left, including feminist organisations, ethnic movements, ecological activism, and health activism. Instead, the Latin American critical approach seeks the equal recognition of all struggles, bound together by the fight against the underlying logic of the contemporary universalist, monocultural, and liberal civilising project of modernity – the so-called *capitalist ethos*. To do so, the meta-critique requires a form of transdisciplinarity that moves beyond the narrowness of contemporary health epistemology, and towards the emancipatory logic of social medicine. Breilh suggested that contemporary social medicine ought to focus both on (i) the material reality of health phenomena, dealing with the 'tip of the iceberg' of the risk factor paradigm, and the recognition of harmful social conditions of the social determinants of health, as well as (ii) critical analysis of the underlying epistemic, symbolic and cultural conditions that reproduce inequalities through social, economic and political process. In this way, the collective health thought style is not merely an account of empirical data about inequalities, nor a call for public health policy and community agency. Instead, the most significant contribution of the ALAMES 'counterhegemony' is suggested to be the refocusing on, and integration of, social processes; and the rekindling of context in health research

from the viewpoint of situated perspectives to provide unique accounts of power imbalances, social asymmetries and systemic injustices in contemporary capitalist hegemony.

According to Laurell, the development of the ALAMES 'counterhegemony' stems from the social and historical character of health practices and knowledge in Latin America. Contrasting the empiricism and positivism of the capitalist model, social medicine rejected the idea that the scientific method effectively suppressed the influence of context and generates truth-facts about reality. Laurell wrote: "The dominant conception of the biological processes in biomedicine…is that these are natural processes, that is, phenomena with no historicity. If it is natural, then social or historical circumstances in which the processes occur cannot transform their essence" (1994:4). Laurell argued that, in denying the historical and social character of biological processes, the *Hegemonic Medical Model* normalised social injustices created by the underlying capitalist biomedicine. Attempts to develop objectiveness in health research, Laurell continued, generate knowledge that favours the dominant classes in the health market. In contrast, Laurell explained that the collective health thought style sides with the subaltern classes, giving voice to and empowering social movements and popular protests that pursue emancipatory objectives in relation to health.

Stemming from the Marxist approach, Laurel highlighted that the ALAMES epistemological alternative mainly focuses on the historical nature of population health and disease, constituting the 'Health and Disease Process'. Laurell explained that the conceptual basis for understanding health and disease as resulting from sociohistorical processes came into the ALAMES collective by way of Laura Conti, an Italian medical doctor and Marxist theorist, whose publications circulated in Latin American social medicine network during the 1970s (Laurell, 2013; Conti, 1972). Hugo Mercer, professor of sociology at public Universidad de Buenos Aires and founding member of the Master's on Social Medicine at UAM-X, explained Conti's work:

> *"The result of her approach is a definition of health and medical practice with its historicity. To construct the definition, the author challenges some of the dominant concepts that consider health as a historically unmodifiable good…It proposes, instead, a definition that links the individual states of 'health and disease' with other individuals in competition with them, understanding that competition is determined by history occurring at different levels of society" (1975:351)*

According to Mercer, Conti isolated health and disease as the predominant object of study in research, and defined it as necessarily linked to the historical trajectory of a society, an approach appropriated by the collective health movement. As Conti explained, the definition of health and disease must demystify the fundamental characteristics of the society, and apprehend health problems as resulting from social phenomena developing throughout a contextual history. Echoing Marx's historical materialism, Conti considered that human history followed the material transformation of nature, found in the development of labour and management of resources in western capitalist societies. Consequently, Mercer concluded, Conti sought to ground the historical character of the health and disease process in the fundamental changes wrought by capitalist ideology on nature, labour, and the means of production. Conti's influence on social medicine was therefore to imagine the empirical basis of the health and disease process not on any type of historical trajectory, but precisely on the Latin American *capitalist* trajectory. Rafael Gonzales, senior lecturer in Social Medicine at UAM-X, and former ALAMES general coordinator, argued that the implications of the capitalist history of Latin America for the health and disease process are best understood through apprehending the boundaries between 'the biological' and 'the social' in contemporary biomedical thinking (2018b).

In his opinion, the ALAMES worldview depicted reality as a relationship between two spheres of life: the biological and the social. The former referred to material processes in nature, the system that 'produces and reproduces' the basis for the survival of life. The biological sphere, Gonzales added, was studied by the natural sciences through disciplines like biochemistry and physiology. The social sphere referred to the system of relationships between people that determined the processes of society. As Gonzales explained, 'the social' includes the economic system, political institutions and the cultural background of a given context, commonly studied by the social sciences and humanities. Though both spheres of life are considered in biomedicine and social medicine, the nature of each sphere, and the way each relates to the other, marks the main difference between 'hegemony' and 'counterhegemony.' For Gonzales, the complexity of 'the biological' is recognised in both approaches as a series of bodily processes that cascade towards the physiological function of organ systems. 'The social', on the other hand, is a complex and intricate field of study in social medicine, while biomedicine simplifies it into linear associations. Laurell sees biomedicine as committed to the reductionist approach to the body, transforming the health causation into narratives about genes, molecules, cells and organs. The resulting knowledge is an abstract notion of the body that claims

objectiveness and universality, while dimly reflecting the sociohistorical embeddedness of health. Laurell argued that, though the capitalist hegemony may find studies of social context useful to help in identifying risk factors, the social sphere was not indispensable to understanding the pathological mechanisms involved in health and disease.

Image 4.2 Online introductory course on Latin American Social Medicine 2018, Session 4 'The response to the Health and Disease Process.' Conversation between Dr. Asa Cristina Laurell (left) and Dr. Rafael Gonzales (right) as part of the academic resources presented to the students. Source: Laurell, 2017c.

Olivia Lopez Olivares, director of the Master's in Social Medicine at UAM-X and former ALAMES coordinator, viewed the *sine qua non* condition that enabled the dialectical transformation of 'the biological' by 'the social' as precisely the complexity which biomedicine does not capture. According to her, the defining characteristic of the collective health thought style is an understanding of 'the social' as primarily constructed by the historical trajectory of a context. The ALAMES collective, Lopez explained, considers that 'the social' is not a sphere of life that exists separated from biology. Instead, 'the social' determines the processes occurring in biology, such that the social sphere is an inherent feature to consider when attempting to understand 'the biological.' For Lopez, history shows the multiple ways people craft a social nature from the biological basis of life, blurring the boundaries between the two spheres and making humanity inherently 'bio-social.' Therefore, Laurell concluded, the emphasis that the 'counterhegemony' of social medicine places on the

historical character of health and disease is a pivotal feature that separates ALAMES from the dominant medical perspective.

To study the bio-social relationship in health, social medicine uses a framework that considers the materialism of biology and the reality of the sociohistorical process equally. "There were many social theories that we could have considered," Lopez explained, "but the collective health perspective in universities abided by historical materialism – that is, we think about humanity from the metanarrative of Marxism" (2018). Laurell argued that social medicine 'counterhegemony' first understands the causal association and mechanisms that impact the physiological processes in the body, similar to the basic sciences in medicine, but then moves on to analyse the social and historical character of bodily changes. The ALAMES epistemology assumes that health and disease do not have an exclusively biological basis, but also required the examination of the 'conditions of development' through which bodily processes are transformed into health status. "These conditions are socially produced," Laurell added, "and are the concrete results of specific historical trajectories corresponding to processes of appropriation of nature (labour and social reproduction) in a given society" (1994:6). This is also conceptualised elsewhere as the 'Metabolismo Sociedad-Naturaleza' (metabolism society-nature in Breilh, 2003a, b, 2010a).

For Laurell, the social environment within which bodies are embedded is the result of the specific forms of transforming nature occurring at a given time and place. Following Conti, the academic explained that the primary process that transforms nature, produces resources and constructs a society in contemporary Latin America is capitalism, reinforcing the use of the Marxist critique to approach the social basis of health and disease. Laurell explained that social medicine opted for Marxist historical materialism because it was 'the only approach' that enabled a proper understanding of social processes, power relations and status asymmetries as a result of the capitalist historical trajectory (2013). "The foundational years of ALAMES were linked with the emergence of the historical materialism and critical perspectives on social repression," Laurell concluded, "we all thought socialism was around the corner" (2017c). Capitalism, she suggested, became the category on which the collective health thought style of ALAMES was built.

The historical approach of Marx nurtured ALAMES' scholars by stressing that the articulation between 'the biological' and 'the social' is not one of 'conjunction' (cause and effect from the risk

factor paradigm), but instead of *subsumption*. Breilh added: “We proposed that the external and internal unity between ‘the biological’ and ‘the social’ does not allow the connection to be reduced to external links alone – the unity of the spheres is granted by the dialectical movement of subsumption” (2010a:101). *Subsumption* refers to encompassing one category within a more comprehensive other which, contrasting other processes like subordination or submission, enables the mutual crafting of their content in a bidirectional or ‘dialectical’ relationship. According to Breilh, the term is grounded in the fundamental observation that the relationship between society and health is a permanent and mutual transformation between the two spheres.

Subsumption emerged as a Marxist category to highlight the structural conditioning of subjects. In the use of the concept, lower levels of determination (the individual or group levels) reproduce the principles, values and objectives of higher levels of society (the state or market levels), in a down-stream or trickle-down dynamic. According to Breilh (2010a), subsumption implies that the structural design of capitalism conditions the lifestyle of consumerism, such that the market is conceived as the totality that orders society from higher political affairs right down to the level of individual behaviour. Likewise, the dialectical movement of subsumption implies the relative autonomy of the parts within this totality. Breilh wrote: "Subsumption does not mean that adhered parts are not capable of reversing the order of subsumption. Both poles, rather, are kept alive" (2017). The use of subsumption by authors like Breilh considers the agency of lower levels of a social system, like the individual and group levels, to shape or transform the reality of higher levels, like the state or the market. Individuals and groups can subvert the structural conditions of capitalism by quickening processes of resistance and transformation, for example. By using the concept of *subsumption*, ALAMES reinforces its commitment to the emancipatory agenda of popular protests and social manifestations.

b) THE SOCIAL DETERMINATION MODEL IN HEALTH:

The dialectical process in subsumption establishes bidirectional transformation among the levels of social determination in health. The ALAMES epistemological alternative suggests that the risk of conceptualising the spheres of determination as a linear association, typical of hegemonic biomedicine, is that the dialectical understanding of causal influences is lost. Consequently, significant themes in social medicine, where biomedical reason shapes broader processes at the

level of culture, politics and economics, like 'biological citizenship' or 'health identities or subjectivities' (Epstein, 1996; Moll, 2002; Katz and Marshall, 2004), are often overlooked by biomedicine.

The ALAMES Health and Disease Process highlights the centrality of the sociohistorical process in the constitution of population well-being, and the way in which social medicine conceptualises population health and disease as a result of historic Latin American capitalism. Nevertheless, the historical nature of health and disease is merely one element of ALAMES' epistemological thesis that seeks to accurately depict the relationship between society and health. The full version must integrate the so-called Social Determination Model, developed most extensively by ALAMES member Jaime Breilh. The Social Determination model reintegrated the intrinsic complexity of the health and disease process within contemporary health epistemology and research, neglected and disregarded by the biomedical reductionism, the 'biologisation' of life and the linear causality of the risk factor paradigm.

It is noteworthy to highlight that the Social Determination model fulfils two unique goals for the ALAMES collective. First, rather than a methodology, the model is an epistemological framework that organises the critical analysis of ALAMES health research. The model is used by researchers as a guide to connect multiple levels of determination in a social system that need to be accounted for when studying the social basis of health and disease in a particular context. The ALAMES epistemological alternative directs the social medicine way of thinking about health and society, so that inquiry begins at the claims of collectives or group-level determination, but then develops towards the demystification of both down-stream (individual lifestyles) and up-stream (state and market ideology) processes of the social system. The model also systematises the empirical elements academics ought to capture in health research, guiding the research gaze towards the analysis of power asymmetries, social injustices and systematic oppression.

Second, following Breilh, the model facilitates the normative evaluation of society according to the so-called 'principles of life' or '*4Ss of life*' (2010a, 2011b, 2013b, 2018a, b, 2019b). The 4Ss are a normative standard, consisting of the principles of sustainability, sovereignty, solidarity and security, which act as benchmarks for concluding whether a social system sponsors or denies 'life.' Breilh explained that the biomedical model is built on the assumption that nature and society exist

in an autonomous, independent state, 'as they are', that is to say, with no underlying value system granting a particular significance to nature's existence other than for the provision of resources (see also Samaja, 2004:53). This assumption is instrumental for wealth accumulation, as it justifies the overt exploitation of nature, and accelerating consumerism that favours the global market economy in health. To justify the scale of resource exploitation that contemporary Latin America upholds, capitalism required the conceptualisation of nature as an object with no particular meaning, history or values, appearing as a mere instrument to be taken and utilised. "It is no exaggeration to state," Breilh commented, "that we currently find ourselves in the real extermination of human beings and the world's ecosystems by a highly destructive system that represents contemporary capitalism" (2019b). According to Breilh, today's capitalism is 'out of control', referring to the impact of the capitalist ethos at the social, communal and individual level. Each domain of the capitalist social determination generates the conditions that deny the 'principles of life' (the 4Ss above), begetting the commitment for health researchers to restore balance into the principles.

Image 4.3 Online introductory course on Latin American Social Medicine 2018, Session 3 'The Social Determination model.' Conversation between Dr. Ana Lucia Casallas (left) and Dr. Jaime Breilh (right) as part of the academic resources presented to the students. Source: Breilh, 2017.

The model is a situated effort from Latin American social medicine to act against the inefficiencies and uncertainties of traditional public health. "The old sciences," as Breilh explained regarding the capitalist model, "made us break down society in little pieces to research what occurs with these pieces and then aggregate them together to conclude that the new artificial picture was public health" (2019a). Consequently, the knowledge generated by traditional public health consists of an academic construct of reality in instrumental terms, defining dimensions to evaluate, creating values to measure, and generating mathematical algorithms to calculate and publish. Breilh argued that contemporary biomedical research is, at best, dimly connected to reality through numbers and, most commonly, entirely oblivious of the social processes of its local context. In functionalist public health "(…) health appears as a value, function and service independent of the rest of society – impeding the study and comprehension of the dynamic relationship between health and the rest of domains in societal processes" (García, 1972 in Duarte-Nunes, 1991:34). Public health, therefore, constitutes a very 'narrow and limited' view of health and disease processes, prompting the crafting of the Social Determination model "to study, demonstrate and generate action upon broader society, the modes of life within groups, and the individual lifestyles" (Breilh, 2019a).

The ALAMES epistemological alternative understands society as a system of 'social reproduction' or the maintenance of liberal societies through the amplification of principles, values and objectives of capital accumulation, realised via individual lifestyles and group habits. No part of society is separated from the concentration of privileges, resources and power in some sectors, typical of the capitalist exclusivism and ultimately impacting bodily processes through the trickle-down effect of biology subsumed within society. Put differently, 'social reproduction' captures the dialectical movement inherent in the relationship between 'the social' and 'the biological.' Additionally, he argues that this same dialectics occurs between levels of determination in such way that research must comprehend all parts of the system (individual, group and general level), but without neglecting the totality that establishes the structure of the system (capitalism) (Breilh, 2010c:9). Breilh argued that the capitalist ideology is sustained only by the 'consumption of the productive basis' of capitalism, referring to a particular type of 'consciousness' among individuals and groups structurally constructed (2003a:72). The capitalist consciousness transforms the innermost desires, longings, affections and inclinations of individuals so that they 'naturally' *reproduce* the political objectives of the market (entrepreneurship, liberalism and individualistic self).

Breilh illustrated ‘social reproduction’ through the logic of transnational corporations in contemporary Latin America. For him, the history of these corporations reveals the need for corrupt practices to guarantee the expansion of business. The enactment of corruption did not merely occur as a result of individuals being 'lured' into questionable ethics once they 'taste power.' "Rather, the very structure of contemporary productivism and the design of the corporate system demands corruption from everyone involved in it – that is, if the goal is to triumph" (2019b). For Breilh, the social reproduction that maintains the model of the corporate system is not a topic of ethics or private values alone, but a structural operation determining the rationale and practices of subjects in society, so that every individual and group emulates the dominant ethos *de facto.* Individuals and groups become blinded to the oppression systematically sustained by class, gender and ethnic inequities - replicating the same practices they likely despise. The social processes that determine population health and disease are, therefore, not inert factors impacting the body in a relationship of conjunction (or linear cause-effect). Rather, society constitutes the essential elements of the individual and group volition through the down-stream consequences of *subsumption*.

The dialectical nature in subsumption not only reveals the down-stream process of social reproduction, but also prompts the understanding of up-stream processes – also termed 'social production' or 'genesis' (Breilh, 2013a:19-20). Breilh suggested that individuals and groups are capable of mediating, regulating and controlling the formation of societal structures to the point of transforming the dominant ideologies, ways of organising society and underlying ethos through the 'historicity' of a context (2010a:100). The bi-directionality of the process discards any possibility of biological or social determinism, recognising the emancipatory potential of grassroots initiatives and social movements. In this way, the Social Determination model distinguishes life’s ‘movements’ in a social system by hierarchical order of forces in the following way: ‘social reproduction’ occurring from higher to lower levels of determination (from societal to individual levels), while ‘social production’ or ‘genesis’ progresses from lower to higher levels of determination (from individual to societal levels) (see Diagram 4.1). As Breilh concluded, the 'resilience' of social systems lies precisely in maintaining the same economic, political, cultural and ethical logic – while the ‘resistance’ of the system emergence from individuals and social groups performing ‘creative’ actions to transform society from the bottom-up (Breilh, 2013c:35).

In general, the ALAMES collective agrees on the notions of subsumption, dialectical movement, social reproduction, social production, and hierarchical social system reviewed above (Almeida-Filho, 1989; Laurell et al., 1977; Samaja, 2004). Nevertheless, the hierarchical levels of social determination differ slightly between authors. For Breilh (2010a, 2020a), the social system is divided into three levels of determination. The macro-level or 'general domain' corresponds to the hegemonic ideology of a society, which includes the civilising project of extractivist capitalism in Latin America, the matrix of the production system, the politics and expressions of the contemporary neoliberal states, and for-profit market principles. The middle-level or 'particular domain,' which harbours social groups and communities under the category of *modes of life*, refers to the typical patterns of expression, beliefs, practices, traditions and collective action of social movements and popular strikes. The micro-level or 'singular domain' is expressed through the individual habits, behaviours or *lifestyles*, alongside the physiological mechanisms of bodily processes and diseases. Within the hierarchy of subsumption, Breilh illustrated, any higher level determines the one below it, so that the macro-level of capital accumulation subsumes the *modes of life* of the particular domain, and the middle-level of social groups or movements subsumes the *lifestyles* of the singular domain. Likewise, the upstream production of the hierarchy follows the same order of determination, where individuals at the singular domain can shape the modes of life of groups, and social movements or collectives can transform the ideology of societies and/or state institutions. The hierarchy of subsumption *a la Breilh* is illustrated in the following diagram:

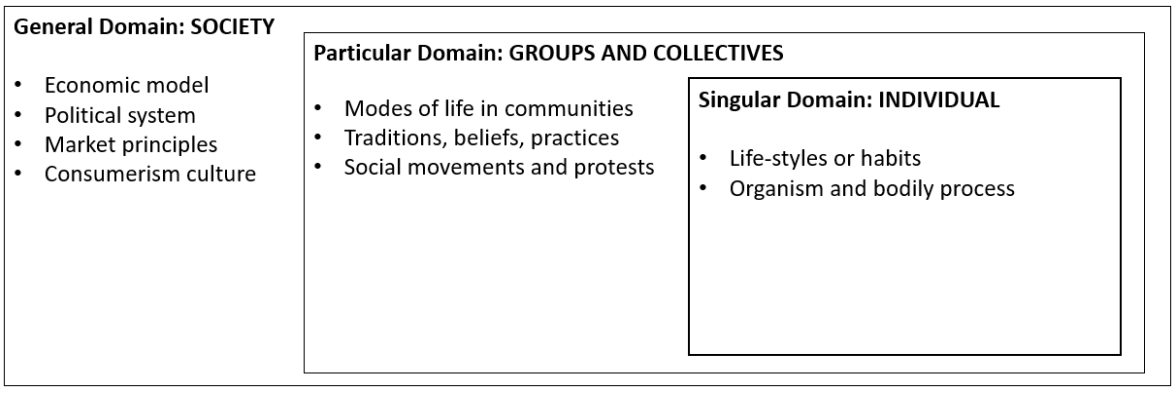

Diagram 4.1 Hierarchies of Social Determination according to Breilh. Source: Adapted from Breilh, 2013:25

Interestingly, Brielh's Social Determination model considers biological mechanism and clinical evidence as part of the singular domain, where the social processes at the mid and macro-level are

embodied by individuals. The ‘social’ and ‘biological’ are understood in non-linear ways, reframing biological processes as social phenomena. Put differently, biomedicine is not rejected in the way depicted by various ALAMES members in the discourse of HMM. Rather, the framework rejects exclusivism or the totalising effect of universalising sciences such as biomedicine. The remark is relevant because, contrasting the unified body that the collective health medicine attempts to portray, various ALAMES members confuse antagonism to biomedical exclusivism as opposition to biomedicine as whole (evidence, reasoning, and practices). In this way, for instance, the XV International ALAMES Conferences often felt like the ‘rallying of troops’ or the ‘call to arms’ against the dominant biomedical system currently oppressing health epistemologies that reason about population health comprehensively. This emergent social medicine ‘exclusivism’ by some ALAMES members rivals and contradicts the very foundational framework upon which the thought collective claims to build upon.

Contrasting Breilh’s model, Samaja argued for the need to further diversify the levels of determination to reflect the historical development of contemporary western societies (1998, 2004). Adding to Breilh's domains, Samaja explained that the trajectory of western history evidences the division of the general domain into two more levels. First, the 'citizenship determination', referring to the collective membership of pedagogical institutions where the subject accesses a historical narrative evoking national identity, patriotic symbols, and the assimilation of political ideals. Samaja described the dynamics of this level as the incorporation into a ‘political society,’ a level of relationship with state institutions resulting from legal frameworks, constitutional rights, and broader moral standards forged in nineteenth-century Europe through the 'social contract' of modern liberal societies. Second, the additional domain of determination at the general level is civil society. This level corresponds to contemporary forms of global market organised in the multiplicity of financial institutions that participate in corporate relationships, for-profit goals and accumulation of capital. The determination of this level reproduces principles of entrepreneurship, market behaviour, and individual responsibility characteristic of twentieth-century capitalism and global finance. Samaja’s framework is illustrated in the following diagram, where readers may appreciate better how the global market is imprinted in all levels of subsumption down to the bodily processes:

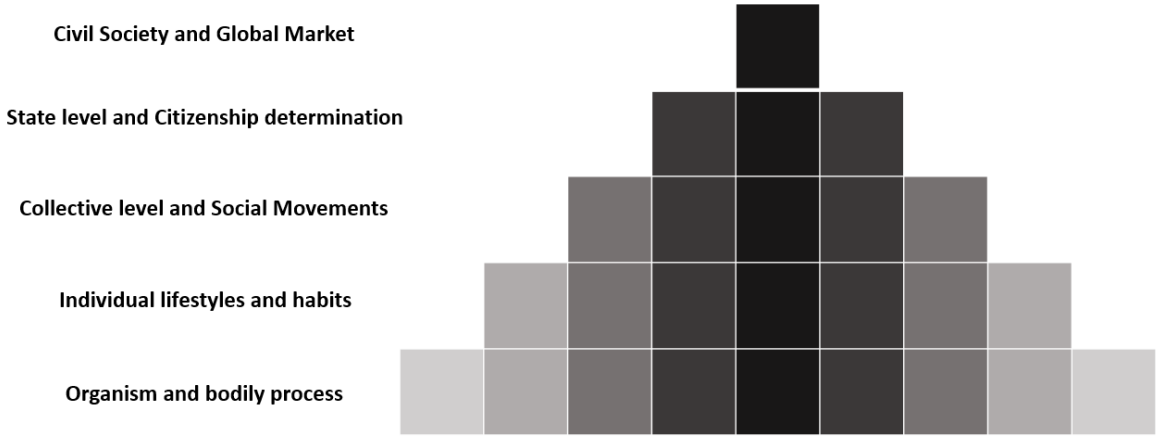

Diagram 4.2 Hierarchies of Social Determination according to Samaja. Source: Adapted from Samaja, 2004:67

In both cases above, we see a particular image of the world, something resembling a metanarrative that intends to capture health causation. Indeed, the Social Determination model in its multiple versions attempt to become theories of health, claiming to capture the underlying social mechanisms explaining population health (economic, political, symbolic and cultural processes impacting health and disease historically). The emerging tension on this matter, nevertheless, is that nowhere in these frameworks do we have a recognition of the particular or situated histories according to the communities experiencing oppression, exploitation or injustice. On the contrary, if we follow the discourses above depicted, we see a clear link of the model to ALAMES' version of twentieth-century Latin American history based on Marxist thinking – assuming the latter epistemology captures the actual struggle of collectives at the ground level. Samaja, for instance, proposes the Social Determination model as stemming of his interpretation of western history (2004). As the next chapter will reveal, once ALAMES actually considers situated narratives and perspectives, the clash re-shapes the thought style in fruitful ways.

Regardless of the levels of determination, the point of the ALAMES approach to health epistemology remains: the Social Determination model is a complex, multidimensional and hierarchical explanatory mechanism that links society and health dialectically. For these authors, the relationship between society and health cannot be reduced to a bundle of empirical factors or variables, causally linked through a linear understanding of reality, as expounded by the *Hegemonic*

Medical Model. To comprehend the origins of the model, the link between the UAM-X process and the trajectory of Jaime Breilh is necessary.

Breilh represents one of the most relevant figures in the collective health movement, with outstanding contributions that have earned him multiple distinctions from universities across Latin America. Breilh's professional trajectory began as a medical doctor at the Central University of Ecuador in the early 1970s. His interest in the role of social conditions in health began during encounters with patients in post-surgery recovery wards, where he "(…) observed that the patients at the hospitals were the product of social circumstances" (Breilh, 2016). As he explained, these early experiences in medicine demonstrated the need for analytical tools that extended beyond the limits of biomedical training, to grasp the relationship between society and health correctly. Frustrated by the limitations of dominant medical practices, Breilh took on research posts, until landing at the Master's on Social Medicine at the UAM-X in 1975, devoting efforts to Latin American social medicine network from then on. Breilh wrote: "During that time, Mexico was at a point of convergence from the intellectual exile provoked by the authoritarian regimes and which, in the field of health, became the centre for critical thinking" (2011:391). Breilh's experience at UAM-X introduced the scholar to Marxist historical materialism through authors like Bolivar Echeverria, Agustin Cueva and Asa Cristina Laurell; challenges to traditional Public Health and *Preventivismo* by way of Sergio Arouca, Juan César García and Eduardo Menéndez; and the critical perspectives of health epistemology of Mario Bunges and Juan Samaja. The author highlighted the significant influence of Ecuadorian philosopher Bolivar Echeverria, who had migrated to Mexico in 1970, escaping the anti-communist political persecution in Ecuador, and developing his professional career at the Universidad Nacional Autonoma de Mexico (UNAM).

Breilh invited Echeverria and Cueva to present their modules at the Master's on Social Medicine in UAM-X during the late 1970s. Though at first the request to teach in the health field was odd for the two philosophers, Echeverria and Cueva accepted, considering the social medicine need to begin research and analysis from an in-depth study of political economy and critical sociology. "Their participation was…the substrate for the creation of a different perspective of 'the social' in the determination of life" (Breilh, 2011a:391). Breilh explained that Echeverria's module on political economy moved away from the economic determinism characteristic of Marxist dogma, and integrated the material basis of other social processes within the communal mode of living,

particularly following Gramsci's hegemony thesis. Elsewhere, Breilh explained the construction of critical thinking in health for the collective health thought style:

> *"(…) the challenge was to substitute the linear thinking for complex thinking, but that goal went hand-in-hand with another philosophical and practical challenge. It was also necessary to overcome the sterile notion, grounded on the modern thought of the '70s and '80s, which professed that the only and inevitable way to organise society revolved around the valorisation of capital and judging things based on its exchange-value" (2013a:29).*

According to Breilh, Echeverria introduced the collective health thought style to the conceptualisation of capitalism not merely as a socioeconomic model, but also as the ethos of modernity, sustained culturally by principles of consumerism, individualism, and anthropocentrism. The dominance of capitalism during the second half of the last century as both a standard to organise society, and a way of reasoning the 'good life'; had a powerful ideological pull that permeated traditional public health. In this way, Breilh continued, social medicine integrated the idea that capitalism did not merely introduced the market logic into financial affairs, but also constituted society's 'common-sense.' The epistemological struggles of ALAMES were the transformation of the ways of reasoning the relationship between health and society, not merely through the revision of clinical thinking and medical practices, but predominantly by questioning the value of health as a commodity. Breilh argued, for example, that the totalising nature of capitalism was responsible for reducing medicine to a bundle of technologies, medications and services so that health problems could not be conceived outside of the healthcare system or biomedical expertise.

Upon the bedrock of the capitalist ethos, Breilh constructed the thesis of the Social Determination model, published for the first time in the book *Economia, Politica y Salud* (Economics, Politics and Health, 1979). The Social Determination model began from the idea that every aspect of the dominant civilisation was not mere circumstance that mechanically related to the body, but rather constituted the inherent features of persons as they live embedded within the capitalist ethos that structurally shaped them. In this way, 'the social' ceased to be perceived as a bundle of inert objects of causation, and instead becames an interactive agent that embodies the ethical, ideological and cultural nature of capitalism, stylising individuals subsumed in the processes of contemporary Latin American societies (Stolkiner, 2001; Samaja, 2004; Stolkiner and Ardila, 2012).

After finishing his Master's degree in 1977, Breilh's academic journey led him to a postgraduate diploma in epidemiology at the London School of Medicine and Tropical Health in 1979, and then a doctoral degree at the *Universidade Federal da Bahia*, Brazil in 2001. On his return to Ecuador at the end of the '70s, he joined Edmundo Granda in the establishment of the *Centro de Estudios y Asesoria en Salud* (CEAS or Health Research and Advisory Centre). The centre was the first Ecuadorian NGO in the field of public health to introduce critical social sciences in the study of health and disease, particularly in the field of agro-industries (Granda, 2009a). Notably, the establishment of the research centre took place at the end of the Ecuadorian military dictatorship of Alfredo Poveda, which had repressed protest against the socioeconomic conditions and the re-establishment of democracy. The CEAS went on to become one of the pivotal research hubs in García's Latin American social medicine network, and was foundational in the emergence of ALAMES at Ouro Preto in 1984. Likewise, Breilh's Social Determination model was consolidated as part of the collective health thought style through the centre's efforts.

IV. CONCLUSION:

This chapter explored the epistemological basis of the ALAMES collective, starting with the critique of the *Hegemonic Medical Model* that stems from the developmental policies, traditional public health and preventive medicine previously explored. It unpacked various lines of critique, including epistemic injustices, the link with historic capitalism, and the linear causation model of health found in the 'risk factor paradigm.' It also linked the *Hegemonic Medical Model* with the Social Determinants of Health literature, unveiling how the collective health thought style opposes the relationship between health and society developed by reductionist fields. Finally, the chapter sought a deeper understanding of 'capitalism' as the key operator in the ALAMES epistemological alternative, through the exploration of the Social Determination model sponsored by social medicine. In so doing, the contrast between *hegemony* and *counterhegemony* was considered, further disclosing the propositions of ALAMES regarding health epistemology, and the reformation of medical education in Latin America.

The chapter reviewed the Social Determination model as the epistemological basis of Latin American social medicine. Through the model, the collective sought to capture the claims and vindications of the social struggles and popular protests in their region, by offering an epistemological framework capable of interpreting their experiences, organising the way to reason the immediate reality, and orienting political action going forward. At the centre of the model, the notion of 'capitalism' within ALAMES features as a driving force that evolved from the socioeconomic model organising society, to the epistemology interpreting the relationship between society and health, and further elaborating towards a 'civilising project' that curates the symbolic and cultural dimensions of everyday life. Social action and emancipatory objectives are therefore bound to the transformation of the underlying capitalist ethos and the re-organisation of societies around a different model of resource distribution. Capitalism for social medicine thus constitutes the fundamental category that grounds the historical character of the health and disease process, and determines the different domains of the social system at the general, particular, and individual level.

As a subject worth exploring in subsequent publications beyond the thesis, the social medicine dichotomy crafted by ALAMES epistemology between the *Hegemonic Medical Model* and the socio-medical thinking of Latin America largely disregards the emerging 'non-linear' fields of biosocial sciences including epigenetics, neuroscience and microbiome research. Emerging evidence in these fields of research resonate with Latin American social medicine by exploring alternative causation models in health, sponsoring similar 'multiple physiologies' discourses, reframing biological cascades as social phenomena, and potentially proposing further anchorage for ALAMES to articulate efficiently with other perspectives from 'hegemonic' evidence-making. Throughout the analysis of the empirical data for this thesis, no mention is given to these publications and the impact these have for the development of social thinking in health and disease – despite biosocial viewpoints aiming at understanding how society is embodied (in similar ways to ALAMES scholarship). The lack of interest and perhaps knowledge on these matters within social medicine's discourse is a significant gap worth exploring further.

Moreover, the devout attention to the artificial dichotomy explored in the chapter also highlights an important paradox of ALAMES' Social Determination model. Whilst the model considers a singular level exploring evidence from the natural sciences, including pathophysiological

mechanisms pivotal for biomedical reasoning; various ALAMES members simultaneously deny or reject biomedical evidence on the basis of its exclusivism, pushing the thought style closer to enacting the very epistemic injustices the collective seeks to abolish. In other words, the very foundational framework that defines ALAMES scholars as 'health thinkers' is also breached by members overtly relying on the dichotomy biomedicine/social medicine. The finding is relevant as it reveals the vast heterogeneity, contestation and disagreement found within the collective. That is to say, the attempts of an ALAMES 'exclusivism' exposes the lack of unification in the corpus of practices – which will be progressively probed in the following chapters.

CHAPTER 5

INTERCULTURALITY IN HEALTH

I. INTRODUCTION:

"(…) health will become transformative when it weaves again with spirituality…because it is in spirituality where the sacredness of health lies...We long for practices that are delivered with the heart - as we say here, practices that have Ajayu. Let us, therefore, have a monguito. We will create a somerito to thank the spirits in this place…We are not just illuminating the path of revolution here in our country but also serving as an inspiration to other revolutions…It is only in acknowledging and finding equilibrium between all forces that we will find the peace we long. Jallalla, dear brothers and sisters."

- **Amauta Gueran at the XV ALAMES International Conference, panel titled "Popular Power and Health in the Philosophy of the Buen Vivir: future challenges for the Abya Yala." 2018**

At the inaugural talk of the XV ALAMES International pre-Conference at La Paz, Bolivia, Amauta Gueran gave a talk entitled "*Buen Vivir* of our *pueblos* from the *Abya Yala* and the future political tasks." *Amauta* is a word that originates from the Quechua '*amawt'*, meaning master or sage, making Gueran a spiritual guide, and a traditional healer in the Latin American indigeneity. He wore a sumptuous *ruana* or thick wool-knitted poncho, embodying an authority that separates him from the crowd. Abiding by his Quechua heritage, Gueran argued that contemporary medical practices misrepresent the unity of individuals by neglecting the metanarratives that bring meaning to life. The transformative potential of ALAMES, Gueran said, resides in its capacity to (re)integrate spirituality into health epistemology.

Gueran held a ceramic pot (*monguito* in Quechua) with a bundle of dry coca leaves burning continuously (*somerito* in Quechua), and recited a prayer in his native language to "…purify the

environment from bad spirits and request the good spirit to reveal the oneness between nature and health" (Gueran, 2018). The smoke emerging from the *somerito* must be pure white, which results from a process that takes place before the rite and involves only Amauta's authoritative hand. As Gueran walked around the auditorium, spreading the smoke and chanting in Quechua, a plastic bag of coca leaves was passed around for each member of the audience to grab and chew, integrating everyone in the process of ritual purification. The rite is quite impactful on/at a personal level - it's rare to be so close to coca leaves without the paranoiac fear of illegality. For the multiple Bolivian farmers attending the conference, nevertheless, coca leaves are the material basis of their spirituality and the only stable source of income their lands provide at the moment. The Amauta's theological language links with the materiality of medical practices through the Quechua term *Ajayu*, meaning soul, spirit, or the vital force that animates life. According to Gueran, reconnecting health to spirituality reinfuses medical practices with the consciousness of the person's innermost feelings, longings, desires and inclinations. In so doing, medicine may return to the fundamental harmony between humanity and nature.

Image 5.1 Amauta Gueran (center right) blessing the *Manguito* and *Somerito* with the help of his indigenous colleague (center left). The banner reads: "XV ALAMES International Conference. Knowledge and Popular Power in the conquest of the right to health and living: The social transformation towards the Buen Vivir."

From left to right, ALAMES Coordination Dr. Rafael Gonzales, Dr. Mario Rovere, Dr. Ana Lucia Casallas. Followed by Amauta Gueran and Colleague, Dr. Rafael Bautista, and Dr. Jose Leon Uzcategui. La Paz, Bolivia. 2018

The stage of the conference caught my attention. An ALAMES flag hung underneath the platform, depicting the American continent upside down - that is, Canada facing downwards and Argentina at the top. The flag is an political statement by the collective, placing Latin America (or *Abya Yala* in Quechua) at the north of the map to challenge the idea of underdevelopment and dependency. On stage the Wiphala Flag hung, a multicolored and squared patterned flag, representing the diversity of the Latin American Indigenous population, otherwise known as *Andinos,* and a notable anti-imperialism symbol. Emira Imaña, ALAMES' Bolivia representative, and the association's newly-appointed general coordinator, addressed the audience: "I'd like to welcome our social organizations that are vanguards of the Right to Health movements which struggle today in Bolivia against all the destabilizing efforts of the *imperialismo yankee* (Yankee Imperialism)" (2018). The use of the term *Yankee* by Imaña, a disdainful word referring to the popular association between the US and the iconic baseball team, revealed the prominent idea that the contemporary healthcare sector in Latin America is a continuation of an imperialist agenda from the Northern country, co-opting various dimensions of local life including labour conditions, public education, food sovereignty, and the quotidian ethos.

This chapter intends to present the interculturality in health according to ALAMES. It will explore ALAMES's debate between social medicine and *Buen Vivir* or Living-Well worldview of the Indigenous movements in Latin America, which has been part of a diversification agenda advanced by the thought style since the late-1990s. During the end of last century, a new wave of social movements emerged against the exponential expansion of neoliberal market policies that jeopardized environmental sustainability and damaged the already stagnant economic development through free-trade agreements and globalisation. The growing Indigenous movements were particularly noticeable for the ALAMES collective, as they provided a new situated perspective about the systemic oppression in Latin America, which the thought style integrated as part of embodying local struggles and emancipatory objectives. The involvement of this new political actor, nevertheless, challenged the ALAMES thought style to consider a postcolonial

interpretation of Latin American history, a more radical approach against western exceptionalism, and the inclusion of other marginalised positions previously neglected.

The thought collective's purpose to integrate the Indigenous ideas was to validate themselves further as a situated thought style that also considered the harmonious relationship with nature and indigeneity – as opposed to the 'death culture' that capitalism systematised in Latin America. The chapter, therefore, scrutinised the collective's perspectives to understand how the social medicine thought style re-imagined its rationale and practices from the standpoint of indigeneity. The goal is to disclose the tensions underlying the ALAMES integration of the *Andino* worldview, noting the competing ideas that are held together in the process of presenting alternative perspectives on the social basis of health and disease. In doing so, the ways interculturality in health are being constructed are unveiled, together with the *Andino* categories that have become instrumental in the social medicine thought style today.

To connect with the *Andino* worldview, the collective health movement interestingly drew on a wealth of literature from other authors who were not ALAMES members, and have only recently been introduced to the thought style. As a result, the original ideas of interculturality do not predominately come from the thought collective itself, but are rather assimilated into the social medicine discourse to determine what *Buen Vivir* looks like within the collective health movement. To explore these aspects, the chapter is organised as follows: a first section elaborates on the *Buen Vivir, Sumak Kawsay,* or Living-Well worldview. The section reviews the ways in which the Indigenous metanarrative challenges basic premises of the social medicine thought style on topics like colonialism in Latin America, the critical analysis of western modernity, and the integration of Indigenous movements in the ALAMES ethos. The second section dives into the trajectory of the collective as it diversified its situated thought style towards indigeneity and the *Buen Vivir.* The uprising of the Indigenous movements in Latin America are highlighted, alongside the tensions from the newly interpreted context, and the challenges of interculturality in ALAMES. The exploration of the debate yields significant shifts in Latin American social medicine, mainly connected with the emerging political subject in the Latin American context: the so-called *pueblos originarios.*

II. THE *SUMAK KAWSAY*, *BUEN VIVIR* OR LIVING-WELL:

a) *BUEN VIVIR* WORLDVIEW:

"Buen Vivir is a way of loving, feeling, thinking, and understanding the world. It is based on the wisdom of our ancestral codes, our ancient cultures and the cultures of life … It is about awakening our truth and recovering our Jiwasa...which is the code that has been protected by our ancestors. It doesn't matter if you are Quechua, Guarani, Cherokee, Cuva, or Salma; it means the same thing. Jiwasa means 'it is not me, but it is us.' It is the death to selfishness, the death to anthropocentrism, the death of Eurocentrism." (Choquehuanca, 2018)

Bolivia's former Minister of Foreign Affairs David Choquehuanca was the keynote speaker on the panel on *Buen Vivir* at the XV ALAMES International pre-conference. Choquehuanca is originally from the Aymara community in Bolivia, well-known for his leadership in Indigenous activism. An early involvement in Marxist political groups enabled Choquehuanca to acquire academic expertise on the history, anthropology and human rights framework of the Indigenous population from higher educational institutions in Cuba and Bolivia. The activist joined the local uprising that overthrew the neoliberal presidency of Gonzalo Sanchez de Lozada, and enabled the rise of Evo Morales to government in 2006. As head of the Foreign Affairs office in Morales's government, Choquehuanca advocated for the *Andino* worldview and the protection of mother-nature or *Pachamama* – gaining prominence among the Indigenous population and international popularity for his spiritually-heavy rhetoric in the political arena. Representatives of the Bolivian Trade Union Confederation of Agricultural Workers at the conference, for instance, addressed Choquehuanca with great reverence, and referred to him as one of the key leaders in the country's struggle for the right to health.

Though Choquehuanca is not part of the collective health movement, his ideas are validated by ALAMES as a reliable contributor to the ongoing debates between the thought style and *Buen Vivir* tradition. According to Choquehuanca, this worldview is a way of reasoning reality grounded in a spiritual-type of knowledge that resides within the 'human soul' and which the Indigenous tradition seeks to protect. The spiritual knowledge of the *Buen Vivir*, Choquehuanca explained, considers a

universal law of solidarity that integrates all ethnic groups into one, and is being degraded by the self-interest of the contemporary market logic. The fundamental problem of contemporary capitalist ethos is the conceptualisation of societies as the aggregation of the individual through contractual agreements, simultaneously dismissing community values connecting people. The underlying objective of indigeneity is, therefore, the return of all political practices to what he calls the *Yuyay* or *Ayllu* – a Quechua term referring to family unity, solidarity, and reciprocity (or *jiwasa*). For Choquehuanca, the Andino *Ayllu* represents a centre of intersubjective determination, an organic ecosystem that harmonises people to rediscover the spiritual knowledge that leads communities towards the fullness of health. The basis of this unity lies in the material connectedness of humanity through mother-nature. Choquehuanca said: "to recover the *Jiwasa* is to know that we are all brothers and sisters fed by the nurturing milk of our *Pachamama*: water…This is why we seek harmony among human beings and harmony with nature" (2018). The goal of the *Buen Vivir,* Choquehuanca concluded, is to find unity or to become 'one for all' - abiding by the ethics of mutual care in the slogan 'I am if you are' or 'I live if you live'.

Choquehuanca illustrated *Buen Vivir* through the Latin American Indigenous agriculture. For the *Andino* population, the production and consumption of food seeks to fulfil needs, while maintaining an optimal equilibrium with the capacity of the land. Indigenous agriculture does not permit the use of chemicals to maximise the production of natural goods, but instead accommodates to the earth's 'natural metabolism.' Though this logic drastically reduces wealth accumulation, the *Sumak Kawsay* is committed primordially to the sustainability and renewal of nature to secure a stable provision of food, maintaining food security while avoiding the exhaustion of the land. The systematic application of the *Andino* epistemology makes the *Jiwasa* a *type of Qullasuyo* - a Quechua term referring to the 'land of healers or eminent people.' As explained elsewhere, indigeneity in Latin America perceives *Buen Vivir* as a situated epistemology whose knowledge 'cures and heals' the earth (Bautista, 2018b). Choquehuanca added:

> *"(…) Buen Vivir is to enable the auto-pachakutiy in us…Pachakutyi is to return to the path of complementarity, the path of wisdom with nature, and the path of harmony…Our struggle is not against our capitalist brothers. Our struggle is for ourselves and them. We do not seek confrontations, but we seek to abolish any form of domination. We seek peace, brotherhood, and happiness…Buen Vivir is about making our own decisions not just through democracy…but through governing*

ourselves. To grant this capacity back to our communities – the capacity to solve our own problems" (2018)

Choquehuanca explained that the *Sumak Kawsay* should also be understood as the renewing of collective living standards unique to the *Andinos*, yet currently marginalised, devaluated, and forgotten by the colonisation of western modernity and contemporary capitalism. The ultimate aspiration of the Indigenous worldview is to empower groups in the self-determination and direct governance of everyday life – a process also termed the *Pachakutiy* (or 'revolution' in Quechua). The Quechua revolution rejects vertical approaches from totalitarian authorities, focusing in the profound transformation of the mode of life of communities, commencing at the individual level and moving up the levels of social engagement. The realisation of the *Jiwasa*, Choquehuanca explained, is constituted from a bottom-up approach that recovers the spirituality of the Indigenous populations. The *Pachakutiy*, therefore, involves a transcendental process of consciousness, sensitivity, and dialogue that sponsors an 'existential transition' (Bautista, 2018b).

Choquehuanca argued that to obtain personal change, individuals must cease to believe the individualist standards upheld by contemporary capitalist societies, replacing them with the metanarrative of the *pueblos originarios* ('original people' in Spanish, referring to indigenous communities). In this way, the *pueblos originarios* constitute a political subject that enables new frameworks to think about self-worth and the significance of society, becoming fundamental actors for emancipatory goals in local struggles of the region (see also, Dussel, 2006). The challenge proposed by *Buen Vivir* is not merely about cultural interchange, but about the conflicting coexistence of a multiplicity of situated epistemologies that seek to reframe the ethical principles of contemporary capitalist societies against the exclusivist nature of its universalising epistemology.

The *Buen Vivir* tradition is also discussed as part of the ALAMES online introductory course to Latin American social medicine. The session on interculturality in health contains a video module recorded by the ALAMES Bolivia representative Antonio Valencia. Valencia is a Bolivian surgeon, former general coordinator of the Bolivian community-medicine residence, and senior lecturer in medical anthropology at the public Universidad Autonoma *Tomás Frías* in Potosi, Bolivia (Valencia, 2010). Interestingly, the video was not developed exclusively for the ALAMES course, but instead belongs to the pedagogical tools of the *Salud Familiar Comunitária Intercultural* (SAFCI or

Intercultural Community Family Health in Spanish). The SAFCI is the health policy and medical residency developed by the Morales administration to sponsor *Buen Vivir* in medical practices, mainly organised by ALAMES former general coordinator Nila Heredia during her role as the Minister of Health. Valencia's intervention, moreover, expanded on the philosophical basis of *Buen Vivir* (Heredia and Lopez, 2014).

For Valencia, the *Pachakutiy* ought to be made more specific for political action. As the author explained: "*Buen Vivir* is based on principles found inside of us, which only the *pueblos originarios* practice. We sponsor *ama llulla, ama suwa, ama qhilla,* the *teko kavi, ivi maraei,* and *qhapac ñan*" (Valencia, 2014), corresponding to mandates like 'do not lie,' 'do not steal,' and 'do not be lazy.' According to the scholar, the *pachakutiy* is the process of decolonisation or emancipation from the western standards of living that seeks the destruction of life and nature. The *Andino* decolonisation is a form of life that functions based on the so-called 'civilising matrix' that the Indigenous population practice and embody, aimed at the protection of the *Pachamama*. Similar to Hacking's concept of 'matrix' (1999), the *Buen Vivir* sponsors "(…) health as the complete harmony with the cosmos, people, families, communities, animals, plants, and all living things in the world as all have equal value" (2014). The exclusiveness of the *pueblos originarios* in embodying the principles above, Valencia continued, emerges from the understanding that Latin America contributed to the most amount of life in the world by producing two thirds of the planet's edible plants. Contrasting to *Buen Vivir*, the 'civilising matrix' of contemporary global market that determines the dominant mode of life in western societies is "(…) against life and the Living-well because it aims at, first and foremost, profit and money with no care to the damage on nature" (2014). As such, aligned to Choquehuanca, Valencia argued that the very essence of the *pueblos originarios* in their ancestral beliefs and traditions is to protect the life of the world from the capitalist ethos.

Interestingly, the *Buen Vivir* worldview challenges the historical basis of contemporary society upheld by the social medicine thought style. ALAMES focused on the trajectory of twentieth-century Latin America to diagnose current states of affairs, and shape the thought style in Marxists terms, putting emphasis on class struggles, labour exploitation, and the oppression of marginalised groups (see chapter three and four). The process of death and destruction by capitalism, nevertheless, stems from the western exceptionalism of colonial times according to the *Andino* tradition. For

Valencia, the violent settlement of the European colonisers in Latin America in the sixteenth-century generated the holocaust of indigeneity on two fronts.

On one hand, the imposed monarchies extended a regime of terror through the open slaughter of *pueblos originarios* in the process of land dispossession. Justified by religious beliefs, the marginalisation of native communities enabled European violence that overpowered Indigenous resistance across the continent. The ensuing forced migration created overpopulated communities in newly established towns or cities, enduring daunting conditions of life that coupled with new epidemics brought by the colonisers producing a mass extermination of *Andinos*. On the other hand, Valencia explained that European colonialism dismantled the epistemological basis of Indigenous populations. He described how indigeneity is based on the expertise of the so-called 'energies of life in nature' that enables the population to create cycles and calendars to determine agricultural practices, management of water supplies, and uses of wind-forces. However, the colonisers "made us believe that they were the ones discovering these truths - it is not like that. They stole our patrimony and took away our knowledge" (Valencia, 2014). The intimate relationship between nature and local knowledge in *Buen Vivir* is such that, through the ongoing colonising process of land dispossession, Europeans settlers not merely stole nature, but also stripped *pueblos originarios* from their rights to care and protect life dictated by their traditions. In doing so, colonial societies disregarded indigeneity, as a way of life and thought style, in disdainful ways at the expense of the sustainability of resources and Mother-Earth (or *Pachamama* in Quechua).

Underlying the processes above, Valencia explained that the civilising matrix of colonial capitalism destroyed the most fundamental aspect of life harmony: the consciousness of spirituality in creation itself. "They have called us idolaters, heretical and pagans because we worshipped everything," Valencia said, "yet, we know everything has life, and everything has spirituality" (Valencia, 2014). Following Choquehuanca and Gueran, Valencia explained that *Buen Vivir* is grounded on the fundamental observation that spirituality is the very basis of life itself. By rejecting spirituality, mainly through the evangelising agenda of the Catholic Church, the knowledge of *pueblos originarios* was also excluded, marginalised and persecuted. The Spanish Inquisition, therefore, constituted a notable overlap of the destruction of capitalism through the epistemic injustices of western exceptionalism. Colonialism, therefore, constitutes a type of epistemic injustice as explored in chapter four.

Image 5.2 Ritual to the *Pachamama* (Mother-Earth in Quechua), performed outside the Ministry of Education during the XV ALAMES International Conference. In the centre of the demi-circle, a group of *Cholitas* (women in traditional outfits from the Bolivian indigenous communities) organise a bonfire to burn as offerings 'to the spirits.' La Paz, Bolivia. 2018.

Though Indigenous communities are fundamental to Latin American ethno-diversity, interculturality in health is a relatively recent phenomenon in the trajectory of the social medicine thought style. The *Andino* communities were integrated into the health struggles only as a result of the uprising of indigeneity across the region at the end of the last century, particularly in countries like Bolivia, Brazil, and Ecuador. This suggests that the exclusion of the Indigenous epistemology, characteristic of the capitalist matrix, is not a distinctive feature of the colonising ethos or contemporary market actors alone. The exclusion is also reproduced by other emancipatory groups who opposed colonialism, including the ALAMES collective, who are structurally conditioned by the dominant

health epistemology (even if positioned as antagonism to it). Such was the argument advanced by guest speaker and writer Rafael Bautista at the XV ALAMES International Conferences. Bautista argued that the ethos that subsumed contemporary Latin American societies extends beyond the structural determination of corporations or capital-driven institutions. Instead, capitalist exclusiveness also conditions counter groups such as ALAMES because the underlying logics that drives capitalism is not the socioeconomic model alone but a symbolic framework and mode of being which intertwines with everyday life at multiple levels. Bautista clarifies:

> *"Capitalism is merely the economic face of something greater that has never received criticism from socialists or the political left. What is this 'greater thing' that makes capitalism possible? Why does capitalism appear after the conquest of the New World, after the invasion and dispossession of our 'Abya Yala' (Latin America)? Well, what makes possible capitalism is the cultural and civilising horizon it stands on: Modernity. If we do not criticise Modernity, capitalism remains alive because capitalism expresses the myths that the modern world has imposed as the only reality possible." (2018b)*

Rafael Bautista is a well-known Aymara Bolivian philosopher, whose contributions to the politics of indigeneity has been pivotal in Latin America. The author mainly focuses on the critique of contemporary capitalism, the lasting influence of colonialism and coloniality in the region[6], and the process of restructuring the Plurinational State of Bolivia. His books include *Marx and Modernity* (Bautista's edited work on Dussel's lectures published by Rincon, 2008), *Towards a Foundation of Critical Thinking: Dialogue between Zemelman, Dussel, and Hinkelammert* (Rincon, 2011) and *The Decolonization of Politics: Introduction to Communitarian Politics* (AGRUCO, 2014). Bautista's shorter pieces are found on independent Spanish-speaking websites such as Rebelion, Telesur, and ALAINET, among many others. He has also been featured in a myriad of talk shows and interviews, elaborating on *Buen Vivir*, the Indigenous metanarrative, and the crisis of contemporary western society.

[6] Anibal Quijano (1988, 2000) first proposed the differentiation between Colonialism and Coloniality. The former refers to the process of dispossession of land, and slaughter of Indigenous populations by the European colonizers since the sixteenth-century in Latin America. The latter constitutes a continuation of domination and subordination through the episteme of contemporary capitalism, even after local emancipation movement from the European Crowns in the nineteenth-century. Coloniality is seen as the perpetuation of colonialism to this day, a mindset or common-sense that enables contemporary phenomena such as economic dependency and political subordination of the 'Global South.' For more details, see also Mignolo, 2005, 2007, 2011.

Bautista reinforced the *Buen Vivir* postcolonial narrative by expanding on the analysis of the Latin American 'modernism' as the root cause of contemporary social injustices. He argued that contemporary societies should be understood not from the foreground of Latin American capitalist socio-economic model but from the 'spiritual anti-spirituality' that grounds the model itself (2016, 2017). For Bautista, the basis of any rationality is mythical, such that 'the Logos does not overcome the Mythos.' He believes the logos of capitalism reproduces the myths that presupposes its rationale and practice, originating in western Modernity brought to Latin America by 'the colonisers.'

Upon encountering the resources of the region, the colonisers sought the possibility of accumulating wealth through the violent dispossession of land and the slaughter of local cultures, Bautista explained. The colonisers required a value system to justify their actions – which they found by the construction of life standards, that is, weighting life differentially between the settlers (superior beings) and the native population (inferior communities). Modernity was grounded in the anthropological classification through which indigeneity was made barbaric, retrograde, and insignificant. For Bautista, the Eurocentric and monocultural western exceptionalism rendered the *Andinos* invisible, subhuman and unworthy; normalising different forms of racism by marginalising the Indigenous spirituality, knowledge, technology, philosophy, and medical practices. Western colonial history uncovers a type of spirituality that rejects other non-western metanarratives to constitute the idea that Europe stands superior to all. Bautista sees that the *anti-spirituality* of modernity was made possible through the near destruction of the *Andino* worldview, and caused the 'original accumulation' that enabled the emergence of capitalism in Europe during subsequent centuries (Bautista, 2018b).

According to Bautista, the disruption of the *Andino* mode of life by European colonialism enabled the imposition of modernity as the incommensurable totality determining the only possible ethos of the new westernised Latin America. In *Buen Vivir* narrative, the colonial rationality of European universalism represents the symbolic murder of *pueblos originarios,* and the oppression of the Indigenous population to this day. Bautista explained that contemporary western societies extend the belief that indigeneity became a 'receding culture with no possibility of transcendence' as a result of the European oppression. In western thought, Indigenous populations cannot be a reference for living because the aboriginals are 'animals without a past, tending towards their disappearance' (Bautista, 2018a). Without an 'archetypal reference from history' to give sense and

significance to their culture, the *Andinos* lack the means to propel towards a progressive future. In other words, Bautista concluded, western historiographies of Latin America systematically disregarded the trajectory of Indigenous epistemologies, such that the local knowledge and ways of reasoning did not stand the test of validity imposed by European science.

To this day, the *Andino* population endure racism across Latin America by being reduced to 'expendable and cheap labour' of capitalist growth (Bautista, 2018c). For Bautista, therefore, the real emancipatory potential in Latin America does not emerge from the working-class, as Marxist dogmatism suggests, but rather from the *pueblos originarios* that have sustained the greatest and longest degrees of dispossession, oppression, and destruction of all people in the *Abya Yala.* Similar to the authors above, Bautista suggested that the *pueblo originario* is the contemporary political subject, destined to lead the social transformation of Latin American societies. Bautista's *Buen Vivir* challenges the social medicine thought style to broaden the scope of its social basis, and include the Indigenous struggle in their ethos.

Bautista argued that western societies offer a civilising horizon that sustains the rationality of modernity. Modernity, he said, presents the *myth* of a future world upon which westerners rely wholly, persuaded by the possibilities, even at the expense of the world's sustainability. The *myth* of modernity nurtures the social reproduction of capitalism through the false promises of the 'infinite progress' (Bautista, 2018a, b, c). Aligned to the long-standing critique of contemporary capitalism in sociology publications (Meadow, 1972; Harding, 1990; MacLellan, 2015; Livingston, 2019), the myth of *infinite progress* refers to the belief that the unlimited economic growth required for social development and the maintenance of contemporary life-styles is indeed possible, despite the limited amount of resources nature can offer. Though there is countless evidence showing otherwise, Bautista concluded that the suicidal essence of contemporary capitalism is made evident by the persistence of consumption, exhaustion of land and exploitation of life in the false conviction that the finite world will somehow become infinite. As he explained: "(…) empirically, the indefinite growth of the economy is unsustainable in a planet that is physically limited, and yet the expectations since the 1970s is a financial pattern called neoliberalism which aims at the systematic accumulation of profit" (2018a). Capitalism generated the renewed agenda of neoliberal reforms, grounded on the western false spirituality of infinite growth, which is incompatible with life itself.

In this way, the *Buen Vivir* narrative also challenges the ALAMES collective to radicalise further their emancipatory agenda, not merely as an issue of population health, but also as a struggle for life in the planet. The continuous exhaustion of resources is found in the work of other authors sponsored by the ALAMES literature. Boaventura de Sousa Santos, professor of sociology at the School of Economics University in Coimbra, and global legal scholar at the University of Warwick, addressed the issue in his iconic book *Epistemologies of the South*:

> *"It is becoming widely accepted that one of the novelties of the new millennium is that it will see capitalism reach its ultimate, ecological limits, that the insatiable exploitation of nature must have an end, lest human life on the planet become unsustainable. This is perhaps the strong question that raises the most perplexity, since all Western thinking, whether critical or not, is grounded on the Cartesian idea that nature is a res extensa and, as such, an unlimited resource unconditionally available to human beings. The answer that Western thought gives to this question is weak because it only recognises the problems that can be discussed within the Cartesian epistemological and ontological model" (2014a:43).*

Santos' connection to the ALAMES collective stems from his friendship with scholar Jaime Breilh, and the affinity of ideas found within the Social Determination model by Breilh (2018b). Santos is a frequent source of ideas and critical perspectives on Latin America for the ALAMES thought, and his work was included in the interculturality module of the online course. According to Santos, the predominance of western modernity globally disabled the Global North from learning and co-existing with the histories and knowledge originating outside of the universal rationality of 'the west.' In his book, he generates ample critiques of western scientific thinking, based on the unsatisfactory and weak answers that the Eurocentric, monocultural, and exclusivist theories of secularisation contributes to the major difficulties of the contemporary world. The author argued that, in sustaining modernity, western societies avoid the difficult task of challenging their fundamental political horizons that generated the current crisis in the first place. In this way, dominant societies reduce the understanding of the world to narrow approaches, such as positivism, pragmatism, empiricism, individualist capitalism, and even some strands of critical theory. The resulting rationality of the west enabled the oppression, marginalisation, and exclusion of situated epistemologies and movements whose ideological basis shared no features with the dominant western culture. Santos proposed that the arbitrary rejection of situated epistemologies in the Latin American epistemic injustices not only includes the critical social sciences (such as ALAMES), but also and most fundamentally the situated epistemologies of *pueblos originarios*.

The ongoing destruction of the planet through the exhaustion of water, land and minerals through the contemporary extraction economy is a consequence of one such unchallenged horizon, Santos believes. Western's *infinite growth* is based on the enlightenment idea that separates nature from humanity, reducing resources to mere objects for instrumental use in the so-called 'extractivist imperialism.' Contrasting the modernist logic, the Indigenous *Buen Vivir* struggles to defend the *Pachamama* as a living organism entitled to its rights against the climate crisis. The urgency for the *Sumak Kawsay* emerges from the disastrous social and environmental consequences of contemporary capitalism including "the destructive impact of unregulated financial capital…the vanishing sustainability of the livelihoods of vast population…the uncontrolled drive for eternal war and violence…the increasing scale of the depletion of natural resources and, finally, the exponential growth of social inequality" (Santos, 2014a:50). Santos agrees with Bautista about the profound transformation necessary in western societies that only emerges through the political subject of the *pueblo originario*. The dire consequences of capitalism can only be tackled, according to Santos, through the rejection of western exceptionalism and epistemological decolonisation of Latin America by radically shifting the foundational civilizing paradigm – a shift possible through integrating the *Buen Vivir* worldview.

b) INTERCULTURALITY IN HEALTH FOR ALAMES:

Interculturality in health by the ALAMES collective is an open conversation between the social medicine thought style and the *Buen Vivir* worldview, emerging from the transformation of the Latin American context in its most recent trajectory. Both approaches are essentially distinctive Latin American epistemologies that share the process of constructing 'objective' facts from shared experiences to create a standpoint representing oppressed groups, and the commitment to an emancipatory agenda grounded on the claims and vindications of the region's social movements. The dialogue between the two social positions creates tensions and ruptures that unveil how social medicine re-imagines itself *vis-a-vis* the challenges from the *Sumak Kawsay*. This section analyses the tension of reconstructing the interculturality in health according to ALAMES.

On one hand, the ALAMES collective, recognising the environmental consequences of contemporary extractivist economies, reimagined contemporary capitalism in neoliberal reforms as the systematic

destruction of life on earth in ways similar to the *Andino Buen Vivir*. The collective health movement shifted towards the critique of neoliberalism to radicalise the collective's resistance beyond the appraisal of the *Hegemonic Medical Model*. Laurell explained that, with the emergence of neoliberalism at the end of the 1980s, ALAMES acquired a more forceful attitude towards capitalism to confront the wave of the free market (2011a). The entrance of neoliberal structural reforms in Latin America led to the intensification of private profit, expanding market principles unprecedented public services, social funds, and more natural resources. Breilh added:

> *"Humanity now faces one of the greatest calamities upon life on earth…the neoliberal machinery is provoking a socioeconomic cataclysm and is renewing the strategy of official terrorism and barbarianism - except this time the endeavour is much more violent as neoliberalism threatens and endangers the people that depend on nature as the means for survival…In other words, it is urgent to create a clear epistemological resistance…that advocates in a frontal and unequivocal way for the great unfinished project of economic, political and cultural emancipation of humanity" (Breilh, 2003a: 27, 32).*

For Breilh, the neoliberal reforms represented the intensification of a rationality dominated by the voracious wealth accumulation that co-opted the interests of the majority by concentrating power on an elite reproducing capitalist politics and culture. Neoliberal reforms in Latin America worsened the impoverishment of living and working conditions by devaluating local Indigenous forms of life, alongside the weakening of the governmental authority, the imposition of market competition, and cutbacks on public funds. Breilh considered this new reality a form of 'terrorism', not through armed violence, but a 'soft' type consisting of the increased social gaps and the destruction of nature. Elsewhere, Breilh argued that contemporary forms of neoliberal imperialism consist of the massive exploitation of resources across Latin America through military manipulation (Breilh, 2010a). In the past decades, some socialist governments in the region have had talks with the Indigenous movements to protect natural reserves by nationalising industries including gold, uranium, lithium, copper, and oil. In response, however, the US government and certain elite sectors of Latin American society have sponsored the militarisation of nearby territories with the intention of intimidating the socialist agenda and favour the free market. For Breilh, therefore, neoliberalism in Latin America is linked with the expansion of military forces and belligerent strategies that perpetuate the terrorism, imperialism, and colonialism of Latin American history.

The panel discussion at the XV ALAMES International Conference entitled 'The Impact of Transnational Capital on the Right to Health' further illustrated the discouraging diagnosis of neoliberalism according to social medicine. Eduardo Espinoza, recently appointed ALAMES coordinator, highlighted: "We are reaching a point of no return, in which life as we know it is being threatened on our planet…Health is impacted by the hyper-consumerism and hyper-exploitation model that is leading us to human suicide" (2018c). For Espinoza, health under capitalism cannot be reduced to the impact of transnational pharmaceutical corporations, privatisation of healthcare services or abysmal costs of emerging technologies. Instead, contemporary capitalism must be conceptualised as a form of living in which societies predominantly organise themselves around market-principles with serious consequences against the planet. Luis Lazo (2018a, b), Peru representative and health activist for ALAMES at *Foro Salud* (Peruvian-based grassroots health forum gathering social organizations across the region), argued that the systematic dispossession of Indigenous territories across Latin America is coordinated and sponsored by states themselves. During the 1990s, the costs of implementing neoliberal reforms led local governments to increasing foreign debt through international financial organisations, including the World Bank and the International Monetary Fund. Under false promises of progress, Lazo continued, states agreed to the conditions of the loans with 'silent' agreements that escaped public scrutiny and deliberation. The financial groups progressively applied conditions by forcing governments to surrender land and resources for the generation of wealth and profit, benefiting transnational corporations. Neoliberalism, therefore, represents the reinforcement of market principles in Latin America at the expense of environmental sustainability.

On top of environmental concerns, the ALAMES discourse also contemplated the social consequences of neoliberalism. Oscar Feo, public health reader at Universidad de Carabobo and former ALAMES general coordinator, explained that the contemporary market 'assault' in Latin America belonged to the 'fourth generational war', or the non-belligerent social conflict that combines economic, psychological, and technological domains (Feo, 2016). According to Feo, "the neoliberal globalisation is a new stage of capitalism that advances imperialism in a political-ideological dominance of total control, imposing elements upon culture and upon life itself based on the market logic" (2018c). The major reason for this new stage, the academic continued, is the US dispute for strategic natural resources to maintain financial, military, and technological dominance in western societies, making use of the historical subordination of Latin America to US

politics. US strategies include the manipulation of government elections, the co-option of governance through international commerce (strict conditions for loans, sanctions upon external debts, market competition, etc.), and the so-called 'soft coups' that delegitimised democratic governments by inciting social protests using false information. Resisting the neoliberal ethos, Feo concluded, implies not merely to oppose financial reforms or to strengthen the protection of the environment, but also the creation of alternative ways of reasoning society, organising experiences and proposing political action that destabilises the basis of the capitalist ethos.

Imaña situates the socially destructive nature of neoliberal policies by explaining the Bolivian experience of the so-called *Alianza para el Progreso* (Alliance for Progress) (2018b). The Alliance for Progress was a programme of financial, political, and social aid to Latin American countries promoted by the US-government in the 1960s and 1970s. Though the programme was applied before the wave of structural reforms in the region, Imaña conceptualised the Alliance as another expression of the neoliberal policies. For the activist, neoliberalism is simply the continuation of the exploitative tendencies of transnational North American corporations in Latin America – a phenomenon that goes back to the 1950s in Bolivia. The overlapping of epochs and ideologies illustrates the ALAMES tendency to conceive neoliberalism as an ongoing multidimensional phenomenon of Latin American capitalism. According to Imaña, the neoliberal Alliance for Progress promoted 'reproductive health' by manipulating vulnerable population into surgical sterilisation at medical centres, promising benefits in return. In this way, the policies sought to eliminate the Indigenous population with 'deceit' and 'co-optation.' Once local leaders found out about the practices, the communities generated rebellions against the medical centres, exposing the policies and ostracising the programme locally. For Imaña, the critical engagement with neoliberalism implies the radicalisation of ALAMES political goals against the renew capital oppression and structural injustices.

On the other hand, not all content from the *Sumak Kawsay* worldview was assimilated by Latin American social medicine, though the ALAMES collective may reference ideas to prompt dialogue. In a separate interview (2018c), Bautista explained that his integration into the ALAMES interculturality emerged from Nila Heredia's invitation as a guest speaker to the 2016 XIV International ALAMES Conference in Paraguay. Since then, Bautista's books feature in extended ALAMES bibliographies, and the academic is often invited to other national and regional social

medicine events. Bautista, nevertheless, is not affiliated to the ALAMES collective, but uses the platform to expand his arguments.

Though Bautista's intervention at the Bolivian conference was met with enthusiasm by the audience – and greatly regarded by ALAMES members during the Q&A sessions – not all members of the collective identified with his approach. Ana Lucia Casallas, former ALAMES coordinator and public health lecturer at the Universidad del Rosario in Colombia, told me: "Bautista is certainly interesting – but he limits interculturality to a form relativism…he tends to recover basic themes from the Indigenous population, like community life, but then takes them as the only possible alternative for society" (2018). Casallas considered Bautista a champion to the cause of indigeneity alone – certainly a worthy commitment, but whose exclusiveness on the *pueblos originarios* limits the possibilities of a broader health epistemology in similar ways to the capitalist biomedical approach. Bautista represents a strand of interculturality that focuses on what Casallas calls 'cultural relativism of indigeneity,' bringing interesting perspectives on decolonisation of thought from the situated experiences of the Indigenous standpoint but lacking the tools to impact the state, the socio-economic model and the integration of grassroots movements beyond the *Andino* population. According to Casallas, the underlying aim of the ALAMES interculturality in health is not merely to incorporate the Indigenous metanarrative and modes of life, but also the co-existence of various ways of thinking in the constitution of knowledge in health. Casallas said:

> *"We cannot remain interpreting interculturality merely as the integration of the Indigenous population. That is to say, thinking interculturality as the reconstruction of the relationship between Indigenous and whites is to reduce the problem to an inappropriate scope. Rather, interculturality is the integration of various ways of thinking health, including the LGBTI, feminist struggles, social class, etc.…Breilh, for example, presents interculturality to better apprehend the asymmetries of power according to ethnicity, gender, age, disabilities and other standards of living. But we cannot start creating ghettos for each group...society encompasses us all in light of our differences" (2018)*

For Casallas, the topic of indigeneity and the emergence of Indigenous social movements in Latin America challenges the ALAMES collective to analyse the ways in which social medicine could be perpetuating western exceptionalism. Casallas explained that indigeneity for ALAMES was the method through which the collective opened its epistemological horizons to consider the construction of knowledge in health from the standpoint of other oppressed or marginalised groups

that differed from the critical social medicine in health of the 1970s. Indigeneity became a first step into the integration of the multiplicity of health epistemologies from other local knowledge and in equal social importance. Aside from the 'deep' structural changes on the socioeconomic model, she said, the ALAMES interculturality in health recognised the need to protect the difference of situated experiences and rejects all possible notions of exclusivism in knowledge-claims. ALAMES interculturality, therefore, is grounded in a strong sense of justice and equality among all *epistemes* to more accurately capture the complexity of population health and most comprehensively construct 'truth' in health. For that purpose, the bottom-up approaches of indigeneity and social movements must be combined with the top-down strategies of structural critical analysis and societal transformation. Otherwise, Casallas concluded, the changes proposed by ALAMES' interculturality remain at the level of legal recognition of ethnic groups, but never permeate the multiple spheres of society already co-opted by the exclusionary ethics of contemporary capitalism.

Saul Franco, former ALAMES coordinator and former director of the Public Health doctoral degree at the public Universidad Nacional de Colombia, added that Latin American social medicine is the 'convergence of thinking', and a 'field of intersection' where various ways of reasoning health overlap. "We have made great advances on these issues through interculturality and the concept of the *Buen Vivir"* (2018). Franco explained that the ALAMES interculturality constituted the integration of two fundamental features of the *Sumak Kawsay* tradition.

First, Franco agreed that the *Buen Vivir* tradition is essential in the recognition of nature as an integral part of health. Assimilating the *Andino* worldview distinguished the social medicine thought style from the instrumental approach to resources sponsored by the *Hegemonic Medical Model.* According to Franco, the *Andino*-situated epistemology enabled ALAMES to remain more sensitive to the consequences of contemporary medical practices, technologies, and research. The intimate relationship with nature of *Buen Vivir* helps the collective health thought style to keep grounded on the multidisciplinary character of the health and disease process. Second, *Buen Vivir* worldview connects Latin American social medicine to broader notions of human dignity and solidarity. As Franco stated, the ultimate objective of social medicine is the adequate comprehension of the relationship between health and society to achieve the highest level of population welfare and well-being. For this objective, the *Buen Vivir* tradition is fundamental, as it sponsors the reciprocal interaction with other human beings, based on the equality of status not merely as individuals, but

as communities with their distinctive practices, beliefs, and rationalities. Franco stated that the fundamental concern of the social medicine thought style "is not merely the interaction among individuals, but the broader relationships in society among groups and collectives on the basis of gender, social class, and ethnicity. Social medicine works on that level of pluralism" (2018).

Jose León Uzcátegui also conceptualised the integration of the Sumak Kawsay as the expansion of the ALAMES situatedness in the Latin American social struggles. Uzcátegui is a retired psychiatrist and doctor in epidemiology from McGill University, whose prominence in ALAMES stems mainly from his leadership at the research node RED-LOMSODES, or Latin American Network of Social Movements for the Right to Health. Currently, the scholar is a distinguished professor of public health at the Universidad de Carabobo in Venezuela, and has extensively supported, both academically and politically, the socialist government of Hugo Chávez Frias. In his lecture series titled 'Health as The *Buen Vivir*' for the Escuela del Poder Popular (School for Popular Power) – part of the pedagogic branch of the Venezuelan Health Ministry; Uzcátegui said of ALAMES interculturality: "What we are proposing is that health cannot exclusively be the care for the ill…Rather, there is a need to incorporate other epistemologies at the same level. It is not one knowledge but a variety of knowledge in health" (2015). For the academic, health epistemology involves the integration of two models: the biomedical model with 'individualistic,' 'curative' and 'hospital-centric' approach, and the 'socio-sanitary model' of collectivity and community engagement represented by ALAMES. He argued that capitalism in health constructed a form of medical practices strictly focused on the management of diseases and healthcare services, also termed *enfermologia* (disease-ology or the science of disease in Spanish; see also Granda, 1990, 2005). The way to achieve *Buen Vivir*, therefore, involves unlearning the exclusivist biomedical viewpoint that structurally determines physicians' and subordinates' medical practices to the generation of surplus value for the pharmaceutical and biotechnology industry.

Contrasting the biomedical approach, Uzcátegui explained that *Buen Vivir* proposes the exact opposite from the dominant medical practices: the so-called *sanologia* (cure-ology or the science of healing). Following Casallas and Franco, *sanologia* consists of the integration of multiple health epistemologies. It also recognizes the need to keep an open conversation with other approaches, under the assumption that viewpoints in health-knowledge are always partial and imperfect, requiring the integration of all claims to properly capture the complexity of population health. The

'pluralism' in health epistemologies, therefore, moves medical approaches away from the positivist, biologicist, and generalising paradigm of biomedicine, and towards the social engagement of situated standpoints in health. According to Uzcátegui, the ALAMES interculturality enabled the conceptualisation of health as more than a medical matter simultaneously associated with multiples domains of society. Ultimately, the assimilation of the *Buen Vivir* worldview in clinical work, offers an alternative paradigm to the 'selfish consumerism' of the global market and the individualism sponsored in the dominant liberal political philosophy. Aligned to Choquehuanca, ALAMES interculturality seeks to ground health epistemology in the principles of community life from the multiplicity of local knowledge, offering a new political horizon of reciprocity, parity, and solidarity.

Blending ideas together, ALAMES's interculturality in health corresponds to both (i) the resistance against the hegemony of contemporary neoliberalism in the consumption of nature and resources, and (ii) the emancipation against the exclusionary phenomena of western exceptionalism in the epistemology of health. The enhanced *counterhegemony* of Latin American social medicine is therefore "the active questioning of standing power and authority…a constant counter-critique" (Fernandez, 2018), and the "synthesis and elaboration of science in health from the experiences and participation of the dominated classes" (Eibenschutz, 1982 in Rojas, 2009:65). In this way, Breilh concluded:

> *"What we vindicate in our counter-hegemonic discourse is the need for the emancipatory narrative to assimilate all the knowledge emerging from the diverse sources of knowing: the academic field, the scientific bases of ancestral pueblos, and even common knowledge that has been systematized in the rural and urban collectives. The objective is to extract all the accumulated knowledge from the multiple sources, in whatever way necessary to construct objects/concepts/fields of action that are counterhegemonic. This move implies summoning all other actors in the construction of knowledge" (2010c:9).*

As Breilh explained, the ALAMES interculturality in health is a 'meta-critical' logic, one where every epistemology is needed, and none is sufficient. Indigeneity, gender, or class epistemologies do not suffice, but rather provide a specific perspective that is grounded in situated experiences and the embodiment of a particular context. Put differently, the differences emerge from the unique forms of oppression, injustices and asymmetries according to each context, modes of living and systems of thought – and they matter. Each context creates a particularised standpoint that determines the

situated thought style, and its resulting knowledge-claim. None of the multiple epistemologies that challenge the basis of capitalism are sufficient on their own. According to Breilh, all situated epistemologies are required in the meta-critical articulation of the ALAMES interculturality in health against the civilising matrix of the capitalist system. Rather than separate disciplines in health, he argued for the integration of all social positions into a transdisciplinary science that is "transcendent, transgressing and transforming" (2019b).

III. DIVERSIFYING LATIN AMERICAN SOCIAL MEDICINE:

The closeness of the ALAMES collective to the political horizon of the *Andino* population progressively emerged from the uprising of multiple Indigenous movements at the end of the last century that forced the diversification of the social medicine thought style. The ALAMES collective was influenced to assimilate the *Buen Vivir* worldview by the multiple processes of governmental restructuring that Indigenous movements led, particularly within the Bolivian government of Evo Morales and Rafael Correa's Ecuadorian leadership. The last section of this chapter explores the shifts in the social medicine thought style to integrate and construct the interculturality in health revised above, beginning with the academic trajectory of Mario Rovere, one of the central references in the consolidation of interculturality in health for ALAMES.

Rovere is an Argentinian physician, former ALAMES coordinator, founder of the Health Sciences Department at the public Universidad Nacional de La Matanza, and former Vice-Minister of Health during the Cristina Fernandez de Kirchner Administration. He was born to a middle-class Christian-catholic family in Buenos Aires, Argentina, and grew up during the late 1960s upheaval of the so-called Liberation Theology in the country. As Rovere described (2018b), Liberation Theology was a series of social movements in Latin American led by Catholic priests, and predominately interested in social equality and alleviation of the population's needs. He joined the movements sponsored by the Catholic church from an early age, where he was introduced to socialist thinking as part of his political activism. Rovere's experience at medical school brought inner conflict as he found opposition towards his interest in the application of social sciences to health from traditional medical thinking. The Latin American political turmoil ignited greater confrontations against

officialism. As he said: "(…) anyone who identifies as 'the generation of the dictatorships' means to say that their lives are not just for themselves – but also for all the other thirty thousand missing colleagues who were not permitted to live" (2018b). Rovere describes himself as a political *militante* of the left-wing Perónismo – representing the frustrated political agenda of former socialist president Juan Domingo Perón. The political and ideological position of Perónismo fuelled the resistance and mobilisation in the 1970s bloody military dictatorship in Argentina, and still represents ongoing struggles of socialist groups in the country.

During the late 1970s, Rovere began a residency in paediatrics, while simultaneously contributing to the recently-established 'social paediatrics movement' in Argentina. As he explained, social paediatrics enabled him to develop his medical career in joint association with various forms of political activism – a rare phenomenon in medical practices at the time. In 1976, nevertheless, the CIA-sponsored military coup against Maria Estela Martinez de Perón (acting president of the third Perón administration) successfully established the so-called *Junta Militar*, a bureaucratic-totalitarian state that lasted until 1983. The regime articulated a strong wave of violence, persecution, and repression linked to the *Plan Condor* policies in the region. Rovere was forced to leave his native Buenos Aires to escape the state terrorism, but lacked the support of the social medicine network explored in previous chapters, which led the physician to join the phenomenon of 'internal exile'. Rovere explained: "I didn't have opportunities to flee from Argentina, so I moved to the province of Salta at the border with Bolivia. I spent the dictatorship regimen there, with the possibility of combining both paediatrics and rural medicine" (2018b). Salta was one of the few towns without the military incursion of the Junta, enabling Rovere to hide safely among the rural population. Being a peripheral town, Rovere explained that the dictatorship had little interest in it, which he took advantage of by extending his medical practices to other nearby villages, and becoming familiarised with the reality of more impoverished regions of the country.

Rovere established close ties with the Bolivian Indigenous communities in rural Argentina - learning the customs of the population, engaging with the *Andino* worldviews, and participating in their local healthcare services. The personal link with Bolivian indigeneity motivated him to support the population as a PAHO representative years later, to contribute to the Indigenous *Movimiento al Socialismo* (MAS or Movement for Socialism) in the struggle to win the presidential elections with the Morales candidature, and to integrate the *Buen Vivir* tradition into ALAMES in the late 1990s.

After the demise of the Junta, Rovere returned to Buenos Aires and became a public health consultant, helping the city's administration on healthcare programmes and medical curriculum reforms. While performing these roles, he was recruited by Maria Isabel Rodriguez in 1985 to join the first cohort of the PAHO International Health Programme in Washington D.C. The process introduced Rovere to the ALAMES collective, where he began connecting and contributing to various research and health programmes across the region. After a short period working at the Peruvian Health Ministry with ALAMES pioneer Carlos Vidal, Rovere relocated to Bolivia as the PAHO representative. During his years in Bolivia, he worked extensively with his colleague, Nila Heredia, in various public health projects, integrating the indigeneity into local medical practices. Rovere's background and interests were pivotal in the realisation of the XV ALAMES conference in Bolivia, and instrumental in the consolidation of the ALAMES interculturality in health during the most recent developments of the thought style.

Rovere argued that Evo Morale's Bolivia represented the pinnacle of the *Andino* governance, recognizing 36 different Indigenous groups as independent nations within the constitution, and sponsoring *Buen Vivir* as the foundation narrative of the so-called Plurinational Bolivian State. According to Rovere, Bolivia stands out as the first country to elect an Indigenous representative as president of a western government in a region otherwise dominated by structural racism and elitism that systematically "subjugated, crushed, luguniated and silenced the *Andino* cultures" (2018a). Morale's *Plurinational* process was based on the de-colonisation of the state through which the Aymara leader managed to aggregate multiple Indigenous movements in unprecedented ways. Rather than proselytising through traditional political parties, Morales achieved presidency three consecutive times, based solely on grassroots movements. The link between governmental affairs and popular struggles in Bolivia constitutes the most successful liberation process in the Latin American emancipatory agenda, according to Rovere. For Rovere, therefore, the integration of the Bolivian *Sumak Kawsay* ought to be a priority for the situated ALAMES epistemology, in full recognition of their social basis in populist movements and the political changes these bring to the Latin American context.

The central theme of the XV ALAMES International Conference nudged at the collective's conceptualisation of indigeneity with the title *'*Popular Knowledge and Power in the conquest of the Right to Health and Life: The Social Transformation towards the *Buen Vivir*.' ALAMES recognised the

centrality of the Indigenous movements in Latin America for the constitution of a new social matrix that resisted contemporary advanced capitalism. The *Andino* worldview represented the political horizon *par excellence* that reignited the importance of situatedness in health epistemology. It cast new meaning to local knowledge about Indigenous communities, and reframed indigeneity as the emerging political subject in the emancipation of Latin American movements. Catalina Eibenschutz, former ALAMES coordinator and distinguished professor of sociology at the UAM-X, defended the *Andino* 'popular participation' as the "exercise of power by an organised community that contrasts the subordinating activities developed by the dominant class or the elitist power structures" (Eibenschutz, 1982 in Rojas, 2009:58). The author argued that 'popular knowledge and power' established a capacity in communities to think and act politically for the objectives of the collective in ways currently unavailable by institutionalised public health and generalising health epistemology. Historically, she continued, the recognition of the *Sumak Kawsay* as an independent source of knowledge and popular power emerged with Indigenous reactions to the advancing policies of the neoliberal reforms during the 1990s, as she wrote:

> *"(Neoliberal globalisation) produced greater inequalities and polarization of our societies, unimaginable levels of wealth accumulation and deepened the social gap between the richest and the poor…This level of injustices could not remain indefinitely and, as a response, the people of the Americas began to rise from the 90s led by, curiously, the Indigenous movements of the region. The struggle against the neoliberal attempts to homogenize the globalized world was questioned by the Indigenous communities, which rose mobilised to demand a more just world in which diversity, plurality and identities have a place" (2009:70).*

Eibenschutz was a highly-respected ALAMES scholar who left a lasting influence through her countless years of activism and academia. Those attending the XV ALAMES Conference gave public ovations to commemorate her lifetime's work, responding to the recent demise of the scholar in 2018. The Mexican physician was born to a first-generation migrant family from Eastern Europe who escaped the Second World War. Eibenschutz graduated as a medical doctor from the Universidad Nacional Autonoma de Mexico (UNAM) in the late 1950s, joining the Cuban healthcare force shortly after the success of the local Revolution. The milieu in Cuba at the time enabled the simultaneous integration of clinical practice and social activism. In 1969, she returned to Mexico to work at the Instituto Medico de Seguridad Social (IMSS or Medical Institution of Social Security), the public healthcare system established in Mexico from the *Desarrollismo* era. "It was like being in a

crystal tower," she wrote, "there was nothing real there. We were dedicated to competing with the major US research groups in a worthless and devious academic race" (2015). According to her, the institutional authorities frequently suppressed discourses associated with the defence of social struggles, to the point of prohibiting her from speaking about any ideas related to the movement in Cuba. By the mid-1970s, given her affiliation to post-revolutionary Cuba and the substantial contributions to the feminist movement in Mexico, Roman Villareal recruited her to join the emerging pedagogical initiative of UAM-X. Through there, and with her particular interest and investment in the relationship between society and health, she became PAHO's representative to the Sandinista government of Nicaragua, and joined the ALAMES collective as both scholar and political activist.

According to Eibenschutz, ALAMES had maintained an anti-capitalist stance, critical of the newer stages of the ideology embodied by Latin America's neoliberal policies of the 1980s and 1990s. These economies reproduced the idea that the modernisation of underdeveloped societies consisted of the homogenisation of people into a model standard of living – one which, for her, sponsored principles like entrepreneurship, capital accumulation and the privatisation of public services. To illustrate the phenomenon in the field of health, she pointed out the rising predominance of international financial organisations, such as the World Bank and the International Monetary Fund. Promising the undelivered resolution of the region's leading healthcare problems, the financial organisations persuaded governments to replace the statist approach with market principles. The massive process of privatisation in Latin America, nevertheless, required large loans from the financial organisations that left the region in overwhelming debt. Under this unsustainable financial situation, local governments became vulnerable to foreign organisations, who took advantage of the situation by conditioning the pardon and/or alleviation of the credits to the advancement of other neoliberal reforms in the 1990s. Rather than the imposition of the capitalist model through totalitarian governments as traditionally experienced in Latin America during most of the first half of the twentieth-century, the enforcement of neoliberalism came by way of the pseudo-democratic strategies of financial manipulation. Ultimately, she concluded, the new structural scheme resulted in more significant health disparities among socioeconomic groups.

Eibenschutz highlighted the stunning response of the Indigenous population to these neoliberal injustices. According to the author, though the general public took action against the wave of

privatisation and commodification of healthcare services, the *Andino* people led popular protests. The strikes did not merely oppose the worsening labour and societal conditions, but distinctively fought for the rights and the protection of nature with unprecedented success. The influence and impact of these Indigenous movements led ALAMES to accommodate the emerging discourses which, coupled with Rovere's experience, structurally enabled the collective's interculturality in health. Juan Cuvi, ALAMES Ecuador representative and senior public health lecturer on environmental health at the public Universidad Andina Simon Bolivar, illustrated the Indigenous movements through the historical trajectory of the *Confederacion de Nacionalidades Indigenas de Ecuador* (CONAIE or Ecuadorian Indigenous Nationalities Confederation), an Indigenous non-governmental organisation whose political agenda consolidated through the socialist party *Pachakutik* in 1995 (Cuvi, 2018, 2019).

According to Cuvi, the heightened advance of the neoliberal policies in the late 1990s drove the CONAIE to mobilise and protest, based on the consolidation of Indigenous national identity, the protection of nature and sustainability of the environment, the struggle for Aboriginal education, the recovery of community rights, and the rejection of the US military forces in Latin America. The uprising "marked a definite turning point in the Ecuadorian society - suddenly, the ignored, excluded, invisible, and silenced population broke out as a central political actor in national life" (2019). Their success, Cuvi highlighted, resulted in the 1998 National Assembly and the 'Ecuadorian Declaration' through which the national constitution recognised the *Plurinational* Indigenous character of the country. The new constitutional status of the *pueblos originarios* was pivotal in the assimilation of Indigenous communities as autonomous political actors who were now able to exercise autonomy and self-governance. Two years later, the persistent exploitation of natural resources and the acquired political power of the indigeneity enabled a new uprising against the government, resulting in the fall of former president Jamil Mahuad. The movements also led to the rise of the Rafael Correa socialist government, although CONAIE withdrew support shortly after, due to the state's "deepening of the economic model aligned with the national monopolistic interests of the upper class and extractivist transnational corporations; a political model that denigrated collective rights" (Cuvi, 2019). Despite the failure in governmental affairs, Cuvi argued that the massive influence of the Indigenous movements in the local politics positioned indigeneity as a rising actor able to transform society through agency and 'popular power'.

For Cuvi, two features are worth highlighting on the impact of the Indigenous movements across the region. The Indigenous movements distinctively challenged neoliberal policies for enhancing the destruction of ecosystems through deforestation, the privatisation of natural resources, the dispossession of land for extractivism, and unregulated mining, etc. In so doing, these struggles successfully turned the common-sense of the population to consider nature and resources as subjects of rights within the legal frameworks of the national constitutions. In Ecuador, the claims and vindications of indigeneity prompted the establishment of a new National Assembly at the canton Montecristi in 2007, which culminated in the proclamation of the *Sumak Kawsay*, and protection of the environment as a constitutional mandate. The new political subject of *pueblos originarios* became "the best expression of resistance to capitalism by dispossession to date" (Cuvi, 2018:24).

Secondly, the Indigenous struggles that developed at the end of the twentieth-century stand out for their commitment to the autonomy of the *Andino* population. According to Cuvi, Latin American governments have historically served as instruments of the ruling elite to subdue the Indigenous population, and legally profit from national resources. Consequently, local governments had varying relationships with the *pueblos originarios*, who remain sceptical about public institutions and state policies to this day. The mistrust towards the state shaped indigeneity to propose a new political horizon in *Buen Vivir*, not merely opposing privatisation and deregulation, but also restoring the right for self-determination in marginalised and oppressed communities. The demand for the protection of the local territory by the *pueblo originarios* challenged the concentrating power on institutions through the centralisation of public affairs. The idea of a *plurinational* state, Cuvi added, must be conceptualised as a basic ingredient of a new 'radical' democracy by indigeneity whereby discriminated groups deploy "direct action and intervention of the public space" (2018:58) - effectively replacing the stagnant version of representative democracy in use today (see also Breilh, 2011a).

Nila Heredia, Bolivian physician, former ALAMES coordinator and Health Minister during the Morales administration, also presented the case of Bolivia as a significant example of the emancipatory agenda of indigeneity in Latin America (Heredia, 2011b; Rovere, 2018b). According to Heredia, the revolutionary efforts of populist Indigenous movements stretch back to the 1952 Bolivian Revolution, where local uprisings achieved the nationalisation of mines, and the enactment

of agrarian reforms against the monopolistic tendencies of the oligarchy in the country. The transformation ended abruptly, however, with the *Coup d'Etat* of 1964 that established a military dictatorship that prohibited unions and left-wing political parties. The situation prompted the rise of the National Liberation Armies (later led by Ernesto "Che" Guevara in 1967) and inaugurated the *guerrilla* conflict in Bolivia. According to Heredia, the turmoil confronted the passivity of local communist parties whose inaction weakened the attempts for other organised class struggles. Several coups followed during the 1970s, weakening the workers' movement until the return of democracy in the early 1980s. The end of the dictatorships left the country with little public participation and politically disorganised, according to Heredia, and it overlapped the abrupt introduction of neoliberal public policies. Though populist movements attempted to restart social transformations after a long wait under illegality, these groups quickly met fierce resistance from national and international financial sectors that left the collective dramatically reduced.

Image 5.3 ALAMES Bolivia workshop in social medicine at the Bolivian Ministry of Health. From left to right ALAMES general coordinators Dr. Mario Rovere (smiling), Dr. Nila Heredia (speaking on the revolutionary indigenous processes throughout the history of twentieth-century Bolivia), Dr. Eduardo Ayllon (ALAMES

Bolivia representative). Rovere and Heredia are close colleagues who met during the establishment of the healthcare system for the indigenous population at the Argentina-Bolivia border during the 1990s. Source: Heredia, 2011b

For Heredia, the final blow against popular movements came during the 1990s with the enactment of austerity laws that facilitated labour uncertainty and the privatisation of resources. These policies made a large portion of workers from the mining industry redundant, striking a blow to the possibilities of working-class struggles that had traditionally constituted the basis for revolutionary change in Bolivia.

Workers were forced back to the agricultural practices in their original Indigenous communities, leaving labour unions with little capacity to summon political action. Though Heredia's narrative present neoliberalism as the power subduing social mobilisation, the scholar also argued that the rampant privatisation shifted the leader of local insurrection from the proletariat to indigeneity. At the beginning of the end of the century, the expanding dispossession of land and exploitation of nature clashed with the Indigenous populations (strengthened by the rural migration of exiled mine-workers) whose only source of survival was being arbitrarily taken away. The conflict led to a series of 'short wars' (the Gas War and the Water War), creating the so-called agrarian movements, made up of former miners of Indigenous origin who had been displaced to the periphery by neoliberal reforms. The increasing politicisation of *pueblos originarios* uniquely enabled the expansion of a *Buen Vivir* worldview based on the sacredness of land, the situatedness of local knowledge, and the dignity of cultures. The Bolivian Indigenous movements joined together in the MAS party which overthrew the presidency of Sanchez de Lozada in 2003, enabling the election of Morales in 2006, and the establishment of the Plurinational State of Bolivia in 2009. Bolivia represents the emergence of Indigenous sovereignty, challenging the modern idea of nation-state, and shifting justice towards the equal value of the *pueblos originarios* in a single political process in western societies.

The transformation of the Indigenous population into indigeneity or political actors pushed the boundaries of cultural recognition to the integration of non-western epistemologies into democracy. The ALAMES interculturality followed this integration by considering the multiple local epistemologies as significant voices in the constitutions of an open-ended way of thinking and acting

upon population health. The endeavour, moreover, represents a renewed move to disrupt the epistemic justices in Latin America. Indeed, stemming from the Indigenous movements in Latin America, the social medicine thought style began a process of diversification to integrate local responses to the socioeconomic, political, and cultural changes during the 1990s. Breilh highlighted the periodisation of the collective health movement:

> *"(…) from the early 1990s onwards…our epistemological project emphasised the need to rethink the subject that generates knowledge and gives way to the longed integration of other ways of producing knowledge that positivism displaced. There lies the importance of the category 'interculturality' for the most recent development of our thought. The amplification and enrichment of the subject corresponded with an equally renewed notion of social organisation which had to integrate subjects no longer under the umbrella of one social movement towards health, which implied an inexistent homogeneity of interpretation and society, but integration of various movements under a formula that was more dialectic and democratic: a popular block for epidemiological action" (2003a:37)*

According to Breilh, the 1980s challenged Latin American social medicine to consider other social injustices associated with health, beyond the limits of the traditional class struggles of its Marxists dogmatism. The ALAMES collective, therefore, began expanding its theoretical basis to consider the complexity of injustices through the so-called 'triple inequities', the production of health inequalities secondary to social class, gender asymmetries and ethnicity discrimination (Breilh, 2003a:36). By the end of the 90s, the rising social phenomenon of indigeneity quickly prioritised the developments of interculturality in the social medicine thought style, producing new challenges in the process of assimilation. Mainly, Breilh explained, the Indigenous movements no longer functioned under a common theoretical framework or philosophical reasoning, but rather represented a myriad of communities with an overlapping political horizon. Instead of aspiring to homogeneity or a unified situated epistemology through collective engagement, traditionally encountered throughout the '60s and '70s, indigeneity proposed to ALAMES the aggregation of movements through principles, values, and objectives, originating from the plurality of local metanarratives. The *Andino* approach created a rupture within the ALAMES collective, which had largely relied on the Marxist historical materialism as a metanarrative, and had not fully considered or associated the local or situated worldview with Indigenous spirituality.

The multiplicity of Indigenous actors emerging in the social sphere implied re-thinking social transformation through political subjects that better represented the *popular* realities of Latin America. The new political subject of *pueblos originarios* led the social medicine thought style to re-imagine emancipatory action as emerging from 'popular blocks' – that is to say, the aggregation of the different *Andino* groups sharing the common perspective of the *Buen Vivir* tradition. Rovere added: "Bolivia is the country where more than half of the population identifies themselves as *pueblo originario* – in such circumstance, the leading role for social transformation is not the working class but the Indigenous population" (2018a). As per Breilh (2003a, b; 2010c), the *Andino* popular block also motivated the search for different ways of producing knowledge in health according to the myriad of actors and methods. Breilh argued that popular knowledge not merely challenges exclusiveness of the biomedical approach, but also questions the pluralism of the ALAMES critical social sciences. Popular knowledge, in this way, sought to integrate the embodied context through the engagement and dialogue among situated epistemologies, while rejecting any universalising attempts to unify knowledge. For Breilh, interculturality in health is Latin America's social medicine attempt to tackle the obstacles to positional diversity, social identities, and shifting pluralism in health.

The shift towards indigeneity decades after the establishment of ALAMES unveils an interesting tension in the local development of the social medicine. Though the collective imagined the thought style as grounded in the social struggles of Latin America, the thought style was now revealing to be a network that inadvertently excluded other marginalised groups – particularly, the indigenous movements in Latin America. Until the assimilation of the *Andino* collectives in the 1990s, ALAMES was unaware of its bias towards its own critical social sciences, largely neglecting the struggles of indigeneity. This was presumably based on the assumption that their own oppressed standpoint represented the situated experiences, concerns, principles and objectives of all other marginalised groups, self-adjudicating a superior status to ALAMES epistemology. Though Latin American social medicine imagined the unification of their situated emancipation from systematic oppression, structural injustices and power asymmetries into one overarching social theory, the *pueblos originarios* made evident that the collective was reproducing the epistemic injustices attributed to the capitalist ethos that ALAMES opposed. Through informal conversations during my time in Bolivia, I came to find that, only in the past five years, ALAMES has generated the opportunity for the direct integration of social movements in the collective health movement through the

establishment of their own distinctive research node. It was at the XV ALAMES International Conference of 2018, that the association established the node RED-LOMSODES to empower movements with their own voices, and agency in the social medicine collective. The finding seems contradictory giving the supposed strong social basis that ALAMES claims to have to social movements and popular protests since the 1970s.

Image 5.4 Panel discussion of the RED-LOMSODES at the XV ALALMES International Conference. At the far left of the picture, RED-LOMSODES coordinator Dr. Mary Luz Martin from ALAMES Paraguay (sitting). First two rows integrated by members of the local Bolivian Indigenous movement wearing their traditional *ruanas*. 2018.

For instance, Breilh's book 'Critical Epidemiology: Emancipatory Science and Interculturality' (Lugar Editorial, 2003a) is one of the early ALAMES publications on interculturality in health, yet, it does not explicitly propose any closeness with the *Andino Buen Vivir* tradition. It somewhat limits itself to the critical appraisal of biomedicine, and its exclusionary practices towards non-dominant ways of producing knowledge in health. Since Breilh's publication, nevertheless, the *Sumak Kawsay*

worldview has been progressively discussed among the ALAMES collective at various public events. One such case is the XIV ALAMES International Conference at Asuncion, Paraguay in 2016, specifically the panel titled "The crisis of the capitalist modernising model and health in the *Pachamama*".

Two elements from the debate at the panel above are worth highlighting. First, the members of the panel conceptualised contemporary capitalism not merely as a way of organising the local and global economy, but also as a system of thought, grounded in modernity and aiming at the structural determination of perspectives, attitudes and lifestyles of individuals and groups. Aligned to the *Buen Vivir* narrative, the panel presented capitalism as a mode of life imputed with moral values, cultural features, and political objectives – in short, an entire ethos originating in preconceived ideas about what constitutes the good life from liberal standards. Second, similar to the claims from indigeneity described above, the panel focused on the consequences of the capitalist ethos on nature, advocating for the recognition of the environment as a subject that feels, acts, responds, and that is worthy of rights. Following the discussion, it is in the context of saving the de-personalising agenda of contemporary capitalism against the *Pachamama* that the horizon of *Buen Vivir* ought to be integrated into the social medicine thought style. The goal of *Buen Vivir* in ALAMES is to restore nature through the integration of 'popular knowledge' (or *Aricandi* in Guarani language) which, for Latin American scholars, corresponds to the situated practices in agriculture, natural medicine, and the protection of local resources. As Marielle Palau, sociologist at the Faculty of Social Sciences of the Universidad Nacional de Asunción in Paraguay, and member of the *Consejo Latinoamericano de Ciencias Sociales* (CLACSO or Latin American Council of Social Sciences), explained at the Conference:

> *"(…) within the Guarani worldview, there is no real separation between humanity and nature. They are both the same thing, the same subject, which I believe is a perspective that is truly fundamental in the construction of a new episteme which aims at Buen Vivir or Sumak Kawsay – that is to say, to debunk the colonial and patriarchal capitalism that, day after day, is exterminating the living conditions of our planet. The alternatives we need to seek to do not come from the laboratory. Rather, they exist already in the memories of the pueblo originario" (2016)*

Palau inaugurated the panel at the ALAMES conference by drawing close attention to the negative consequences of contemporary capitalism on the *Pachamama,* using the case of Paraguay as an

example. According to Palau, Paraguay is characteristic for implementing neoliberal policies that enabled both the incursion of transnational industries, and the deregulation of land ownership. The consequence of the phenomenon was that market forces exhausted land capacity. Palau highlights that out of the 18% of the land dedicated to agriculture, 94% of it is devoted to soya plantations from transnational corporations that advances production at alarming rates. At the same time, this process invaded Indigenous communities, and destroys fragile environments that made the harvesting of other food by local farmers impossible. The logic of the so-called agro-business in Paraguay trumps national food sovereignty, endangers the sustainability of local communities, and exposes nature to further hazards such as deforestation, water contamination, and animal extinction. Palau connected her diagnosis with recent statistics on population demography, attributing the massive rural to urban migration to the capitalist processes above that resulted in the exponential rise of poverty levels, and the growth of social inequalities. The author concluded by labelling the phenomenon 'eco-suicide', or the extermination of life as we know it.

According to her, the context in which Latin America found itself as a result of agro-business calls for alternative ways of organising society that functions by the laws of harmony and protection of life. She said: "(…) the alternatives have been developing inside of communities - particularly within *pueblos originarios*, through the constitutions of popular movements that propose different ways to break away from the contemporary patterns of productivity" (Palau, 2016). Palau highlighted that the commitment to emancipate from the capitalist ethos is found in the Indigenous movements, who vividly protest against the dispossession of their sacred land, and the exhaustion of the resources. Like the *Buen Vivir* narrative, indigeneity is presented as the unique and situated active political subject that emerged in the continuous struggle for de-colonisation with unprecedented effectiveness, enabling the self-governance of local communities for the first time in recent decades. Palau's *pueblo originario* aligns with Breilh's *popular block,* expanding the ALAMES social basis beyond the engagement with critical social theory, and to the integration of the Indigenous spirituality. The decolonising struggle of the *pueblo originario*¸ Palau concluded, consists of forms of 'radical democracy' in which populations exercise direct governance on their daily affairs, expecting all types of authority to fulfil the Zapatista motto: "(…) *Aqui manda el Pueblo y el Gobierno obedece*" (Palau, 2016 – Spanish for 'In this place the *pueblo* rules and the Government obeys').

Along the same lines of reasoning, other authors found the ALAMES interculturality bibliography contributed to the assimilation of *pueblo originario* as the next political frontier. Jorge Viaña, senior lecturer in economics at the Universidad Mayor de San Andres in Bolivia, former-director of the Centro de Investigaciones Sociales (Center for Social Research – research branch of the Vice-President of the Morales government), and strong advocate for the indigeneity scholarship in Bolivia stated: "Critical interculturality seeks an intervention in the parity between subordinated and dominant groups, to re-construct liberal institutions, and ensure a new type of democracy with direct engagement – that is, integrating the practices and traditions of the Indigenous communities" (Viaña et al., 2010a:11). According to him, interculturality is a process to enable 'direct democracy' through reimagining state roles and public participation in such way that the standpoints of groups that reside outside of the epistemic coordinates of dominant thought styles are also included. To achieve this goal, nevertheless, western societies must 'reverse the correlation of forces' that create such arbitrary distances between universalising epistemologies and local knowledge, where the former are granted authority while the latter is dismissed and rendered invisible. The transformation of interculturality at the political level, therefore, involves the re-contextualisation of generalising approaches, where governmental vertical measure in health depends entirely on the situated perspective of local positions.

Viaña argued that the term 'interculturality,' though helpful in the recognition of indigeneity, required further analysis of the contemporary affairs of capitalist societies. He explained that the term emerged as a substitute of the politically sterile concept of *multiculturality*, a notion which achieved the nominal acknowledgment of diversity, but failed to consider differing worldviews seriously - leaving the multiculturalist project a mere 'recognition of cultural relativity' (Viaña, 2010a:10). The objective of interculturality was to engage cultures and dialogues between situated perspectives through principles like respect, co-existence, tolerance, and equality. However, after revising authors like Kymlicka and Rawls, Viaña argued that the notion of interculturality is often co-opted by liberal and capitalist ideas, only to reproduce the same exclusionary tendencies of previous projects, while still maintaining the structural discrimination of western exceptionalism.

Viaña argued that dominant political circles in contemporary Latin America apply the *liberal* version of interculturality that interprets equality as the contractual agreement among parts to follow a particular set of rules and regulations in settlement of disputes. These rules and regulations,

nevertheless, do not integrate any fundamental elements of the worldviews, but rather silence the real disagreement underlying the clash of political horizons. The 'legalistic recipe' of liberal interculturality (Viaña, 2009:8) keeps the fundamental asymmetries of the contemporary capitalist ethos intact, and these are precisely the core pillars that the *Buen Vivir* tradition in ALAMES struggled against. Because of the lack of critical analysis to unveil these fundamental errors, Viaña argued that the inclusion proposed by liberal interculturality enabled the subordination of the Indigenous population to the supremacy of the market.

In response to the diagnosis, Viaña advocated for the so-called 'critical' interculturality. The addition of the term 'critical' seeks to establish an approach that demystified the market-driven injustices, and the monocultural oppression of neoliberalism in Latin America, achieving real emancipation from the capitalist ethos. Stemming directly from the *Sumak Kawsay* of *pueblos originarios,* Viaña's critical interculturality prompted the ALAMES thought style to embrace indigeneity as the political actor, proposing two transformative changes in the region: (i) the possibility of a direct democracy whereby communities are able to exercise autonomous forms of governance, and (ii) the real integration of diverging societal projects, beginning with the Indigenous movements found in local struggles. As Viaña stated elsewhere: "If we integrate direct democracy, not merely representative and participatory processes but the direct involvement through collective structures of deliberation and decision…then we achieve a true qualitative transformation of current democracy" (2009:46). For the author, Latin America could not remain at the level of recognising individual rights, but ought to consider the autonomy of Indigenous communities by deepening in collective rights, as well as debunking the commodification of nature and health. He understood the *pueblo originario* as the sovereign subject in the exercise of political and societal power, whose will represented the basis of any governmental authority, and thus ought to be protected by the constitution and public institutions.

Aligning with Viaña, other authors in the ALAMES literature on interculturality also conceptualised the *pueblo originario* as the new political subject necessary for the emerging processes of social transformation in Latin America. Estermann considered the *pueblo* as Indigenous groups in the ongoing process of emancipation and self-determination that was always "open and inconclusive, requiring a long-term historical effort and a 'utopic' potential" (Estermann, 2009 in Viaña et al., 2009:59-60). Fornet-Betancourt (2009), argued that the *pueblo originario* is the predominant actor

that problematises the monologue of westernised and Eurocentric discourse of culture, as part of the clash of forces in the history of liberation movements. Anaya understood *pueblos originarios* as autonomous communities in their social processes when he highlighted: "the Indigenous *pueblos*…struggle against the endemic inequalities that derived from the historical guidelines of colonialism…appealing to international law as an instrument to support their cause" (2005:26). Other ALAMES members considered the important role of the *pueblo* in the revolutionary changes sought by the social medicine thought style. Oscar Feo advocated for the necessity to surpass capitalism through the determination of a new social model that reconstructed political relationships outside the domain of the market, and associated financial logics. He stated: "this processes of indigeneity can only be accomplished if these alternatives are imagined, designed and constructed by and with the *pueblo originario"* (Feo et al., 2012) – that is to say, through situated epistemologies. For Feo, to consider *pueblo* as the new political subjects to re-invent and radicalise democracy, promoting direct participation that subordinated governmental institutions to the will of the people. The *Buen Vivir* of *pueblos originarios* challenged ALAMES to consider a transformation from different types of grassroots initiatives, to the ones historically determining the thought collective. The new agent of transformation, therefore, became the *pueblo.*

The proposition of critical interculturality by the authors above certainly presented various challenges to Breilh's attempts in the conversation. Though Breilh's objective aligned with Viaña (in that both sought alternatives to the dominant views of contemporary society), *critical* interculturality is wholly grounded in the *pueblos originarios.* Breilh's interculturality, in contrast, considered inclusion but without a footing in any situated metanarrative. By lacking such a footing, Viaña's critique of *liberal* interculturality also applies to Breilh's approach, whose interculturality in health runs the risk of becoming another form of cultural relativism. It is unable to critically assess the value or worth of the myriad of elements emerging in the engagement of contrasting worldviews. As a result, social medicine risks embracing the liberal idea of inclusiveness through contractual agreement of a legal framework. Though Breilh may not have intended to sponsor the market logic, a lack of grounding in a metanarrative that enabled to judge in absolute terms (good vs bad, right vs wrong, normal vs pathological), left the less dominant worldviews vulnerable to greater societal forces, including the global market logic of neoliberal reforms. It may be the case that, as a result of the challenges of *critical* interculturality as described above, the social medicine thought style began to integrate the *Andino Sumak Kawsay* somewhere between Breilh's

publication (2003a) and Viaña's integration in the collective's literature (2010s). The result of this combination led to the XV International ALAMES Conference in Bolivia, and the development of the overarching theme of the *Sumak Kawsay* in the debates.

IV. CONCLUSION:

This chapter explored the ALAMES interculturality in health that proposed a dialogue between the social medicine thought style and the *Buen Vivir* worldview of the local Indigenous communities. Rather than exploring the Indigenous way of thinking *per se*, the aim was to analyse the features of the *Andino* narrative in the most recent developments of the situated ALAMES thought style. Given the vast diversity of Indigenous communities in the region, ALAMES predominately considered the discourse emerging from the Quechua and the Aymara communities – Indigenous people who belong to the eastern and mid-eastern areas of the Andes. The *Sumak Kawsay* stems from the metanarrative, worldview, and mode of life idiosyncratic of the *Andino.* It is a term that intends to rationally denunciate the beliefs, myths and principles of the Indigenous people of Latin America. Moreover, *Buen Vivir* is a political horizon and social objective that Indigenous communities aim to reach, prompting them to live in a reciprocal, complementary and harmonious relationship with themselves, others and nature. For the collective health movement, *Buen Vivir* reintroduced the theme of spirituality in the contemporary form of thinking and acting on health, in clear opposition to the so-called modernist way of life.

To evaluate the content and relevance of the *Sumak Kawsay* in the social medicine thought style, this chapter reviewed the contribution made by scholars and experts of the *Andino* worldview that have been integrated into ALAMES through seminars, conferences, and literature. The first section explored the *Buen Vivir* tradition to analyse the ways the *Andino* worldview sat within social medicine. The encounter of perspectives created tensions with the core rationale and practices of the thought collective, and prompted changes on the conceptualization of social medicine in Latin America. This narrative challenged ALAMES to: (i) reinterpret the Latin American context as emerging from colonialism and perpetuated in contemporary coloniality, (ii) radicalize the critique of the capitalist ethos based on the rights to nature, (iii) re-engage with the analysis of modernity,

and the myth of *infinite progress* as the underlying rationality in contemporary capitalism, and (iv) evaluate the reproduction of western exceptionalism within the rationale and practices of the social medicine thought style. As a result, the ALAMES interculturality emerged with a distinctive conceptualisation of its counterhegemony, recognising the destructive nature of neoliberal policies since the 1980s, and attuned with the integration of multiples epistemologies to most accurately grasp the complex relationship between society and health.

The second section explored various elements of the process to diversify ALAMES and encompass a *Buen Vivir* worldview. From the voices of Mario Rovere, Catalina Eibenschutz, Juan Cuvi, Nila Heredia and Jaime Breilh, the ALAMES interculturality in health was linked to the collective's attempts to accommodate changes in the Latin American socio-political context as a result of the region's Indigenous uprising. As a consequence, Latin American social medicine faced the challenges of integrating Indigenous movements as political actors in their own right, extending the epistemological basis from the class struggles, to the dispossession of land, and the exhaustion of resources in Latin America. This instigated a re-evaluation of the challenges of so-called *critical* interculturality.

CHAPTER 6

RIGHT TO HEALTH FOR LATIN AMERICAN SOCIAL MEDICINE

I. INTRODUCTION:

"It is pivotal to understand in this debate that not everybody talks about the same thing when referring to human rights. There is an understanding of rights strongly linked to political liberties…which is instrumental to global capitalism…This perspective evokes the idea that, first, I have my rights covered at the expense of the rights of others; and second…that other people impose restrictions on the unlimited expansion of my desires by demanding their rights over and above the collective ones."

- **Alicia Stolkiner at the panel titled 'Collective Health within the Human Rights perspective,' XIII International ALAMES pre-Conference. Buenos Aires, Argentina. 2014**

The 'right to health' is a prominent topic of analysis in contemporary global health, due to the growing number of governments that integrate this mandate as a constitutional decree (Olesen, 2006; Maleche and Day, 2014; Yamin, 2017). Constitutional mandates on health now hold governments accountable to fulfil specific duties for their citizens, particularly linked with the provision of medications and high-end technology. These mandates can come into tension with other collective affairs, including alleviating health inequities, long-term planning in healthcare, rational priority setting in social policy, and the role of democratic institutions in population health (Sieder et al., 2005; Gable, 2007; Gloppen, 2008; Reubi, 2013). For ALAMES, the 'right to health' is the *collective* entitlement to access a specific type of healthcare system, otherwise known as *Sistema Unico de Salud* (unified healthcare system or SUS). The SUS guarantees the access to healthcare services and resources, coupled with action on the social determination of health through the so-called 'democratisation of health' (incorporation of social movements and local collective to the decision-making process in healthcare).

To address the healthcare system in terms of rights, however, is a fairly recent phenomenon in ALAMES. It predominately stems from the need to use an effective language of resistance at a time when the neoliberal wave of reforms were emerging, and socialist politics were rapidly losing strength – that is, at the end of the twentieth-century. Before then, the issue of healthcare was framed in terms of social security nets, state responsibility and solidarity in the context of the Welfare State. This chapter elaborates on the situated perspective of the Latin American social medicine over the 'right to health', and how it came to be operationalised by conflating rights with a comprehensive healthcare system.

The 'right to health' as access to a healthcare system according to ALAMES clashes with discussions on the topic in broader literature. Most publications outside collective health highlight the tendency that began during the last two decades of the twentieth-century to construe the 'right to health' as an *individual* (not collective) entitlement to access essential medications and expensive pharmaceuticals (Biehl et al., 2009, 2012; Petryna, 2009a, b; Motta, 2013). As such, patients who were denied treatment by medical prescription could use the national courts, and begin judiciary processes to guarantee state intervention and receive the resources. As the phenomenon of judicialization has expanded, a multiplicity of actors in global health have devoted enormous efforts in making high-technology drugs and services available to all, through the formidable markets that governments secure when following court decrees. Most importantly, by interpreting health purely in pharmaceutical and medical terms alone, the 'right to health' concentrated national and international interest on individual claims at the expense of appropriate action on the economic, political, social and cultural determinants of health. The 'right to health', therefore, led authors to explore the progression of the so-called 'pharmaceuticalisation' of public health, whereby "(…) public health is now understood less as prevention and primary care and more as access to medicines and community-outsource care…" (Biehl, 2013:424). As Biehl explained, the pharmaceuticalisation of public health created tensions between the objectives of 'right to health', as access to medicine, versus the collective goals of public health – the former occurring at the expense of the latter.

Despite the difficulties in the use of the term, 'right to health' remains relevant for contemporary societies. Today's circumstances demand ways of reasoning about the social determinants of health

beyond the exclusiveness of medical approaches. In particular, the COVID-19 pandemic has pressured governments to meet population needs at different levels not traditionally encountered by biomedicine. One would imagine that, as the rights discourse is commonly associated with liberal arguments of citizenship, holding high standing in neoliberal societies; it would be an anathema for the Marxist-based ALAMES (which aim at the radical transformation of capitalist, liberal and monocultural societies). However, this thesis problematises these assumptions by following through the arguments of the social medicine collective on the matter. ALAMES challenges the 'pharmaceuticalisation of public health', aims at moving pass court-mandates, and focuses the debate of 'right' on the broader objectives that healthcare system ought to have (Stolkiner, 2010; Gonzales et al., 2014; Heredia et al., 2015; Telteboin and Laurell, 2015). ALAMES adopted the language of rights in the 1990s-2000s, modifying it to a more comprehensive approach beyond an individual's access to drugs that more efficiently fitted its political goals. This chapter provides a collective history that resituates the notion of 'right to health' for Latin American social medicine as the articulation of biomedical practices (such as pharmaceuticals and health technologies) with other approaches that impact the social basis of health and disease.

This issue was discussed at the XIII International ALAMES pre-Conference in Buenos Aires, Argentina, where the quote at the beginning of this chapter originates. Alicia Stolkiner, former ALAMES general coordinator and professor of psychology at the public Universidad de Buenos Aires, argued that the neoliberal structural reforms in Latin America narrowed the scope of the 'right to health' to consider solely the phenomenon of judicialization. The introduction of market principles in healthcare in the 1990s, Stolkiner explained, progressively transformed health from comprehensive actions improving human welfare to contracts with insurance companies for the expansion of transnational capitalism (see also Abadia-Barrero, 2016; Hernandez, 2018b). Consequently, rather than a collective principle, the 'right to health' in the spirit of capitalist competitiveness implied that entitlements would be fulfilled by the state in favour of individual self-interest. Provided individual desires remained inclined towards high-technology drugs and interventions, the dominant perspective on the 'right to health' encouraged the ever-expanding global capital of pharmaceuticals and privatisation of healthcare. The neoliberal approach to 'right to health' defined it in individual terms, transforming the issue into a sphere of dispute and resistance for ALAMES.

This chapter is divided into three segments. The first considers the Brazilian sanitary reform, advanced by the *Sanitarista* movement in the '70s and '80s. It represents one of the first attempts in the region, certainly the most successful so far, to incorporate access to the SUS model as an issue of 'right to health' and constitutional rights. Though the reform instituted a much-needed universal, publicly-funded, and free-of-charge healthcare system for the population; members of the collective health movement considered the triumph as falling short of its original political promises. The development of the Brazilian sanitary reform shifted from 'rights' as access to a healthcare system to 'rights' as access to medications or the 'pharmaceuticalisation of public health'. The phenomenon resulted from various conditions: the access to antiretroviral drugs for HIV/AIDS, the pervasiveness to neoliberal policies in health, and the ambiguities towards public health by Brazilian governments in the late twentieth-century. Consequently, local courts reinterpreted the 'right to health' as individual entitlements claimed legally through constitutional mandates, trumping the intended democratisation of health by the *Sanitarista* movement.

The second segment will explore the SUS as ALAMES's healthcare system that is grounded on the idea of 'right to health' beyond the pharmaceuticalisation of public health, and action on the social determination of health. As will become apparent, the association's incorporation of the 'right to health' discourse bowed to the recovery of the *Sanitarista's* political goals, and the adoption of the rights language in the 1990s and 2000s. The uptake of 'right to health' as part of the SUS model by the end of the last century suggests the collective health movement's strategy to remain relevant. This was especially so amidst the demise of social welfare policies and lack of comprehensive public health reforms that were the result of a wave of neoliberal reforms worldwide at the time. This segment explores the neoliberal healthcare system model known as *Cobertura Universal de la Salud* (CUS or Universal Health Coverage), and the social medicine response to this system by emphasizing the relevance of social security nets, as well as state responsibility over population health. The exploration of the ALAMES unified healthcare system reveals the inclination to integrate the institutional approach to healthcare delivery, and the broader concern towards the democratisation of health.

The third segment of the chapter zooms in on shifts in the healthcare system model according to ALAMES from the foundational years of the association to current times. The implications of transitioning from a militant to the association's political stage in its development will be

highlighted. The militant period corresponds to ALAMES members in academia focusing on critical analysis and scholarly engagement with the affairs of advanced capitalism at the end of the century. The political stage refers to the rise of the Latin American left-wing *progresismo* governments in the twenty-first century, where members of the social medicine collective took on governmental posts, and applied the SUS model locally. The historicity of the SUS model reveals two underlying features of the collective health movement. On one side, the collective health movements reframed healthcare system concerns from welfarism and solidarity in the '80s to arguments in terms of 'rights' with the advent of the CUS in the late 1990s. On the other side, this segment unveils the ways in which ALAMES redirected the 'right to health' as access to SUS in the early 2000s to an exclusive focus on the financial sustainability of the system during the *progresismo* governments. Similar to Brazil's sanitary reform, ALAMES members in government posts limited the efforts to democratise health by the SUS model in order to maintain the political efficiency of their public offices. The move, nevertheless, questions the capacity of the collective to remain militant in the context of a growing global health market.

II. BRAZILIAN SANITARY REFORM AND THE JUDICIALISATION OF HEALTH:

ALAMES social medicine has political and ideological commonalities with the Brazilian collective health movement, each representing a distinctive branch of left-wing politics in the region. Though the characterisation of the two strands extends beyond the scope of this thesis, an overlapping point of interest is found in the SUS healthcare model. Brazil's activism and public health reforms that fed into the 1988 constitutional assembly, shaped the contemporary conception of the social medicine 'right to health' as access to healthcare system once the collective acquired this language at the end of the twentieth-century. This segment explores the Brazilian sanitary reform, unveiling the tensions between the movement's focus on the access to SUS, and the political realities emphasizing access to pharmaceuticals.

Following more than two decades of military dictatorship in Brazil, the moves to return to democracy in the mid-1980s enabled the success of a coalition known as the *sanitarismo* movement. The movement brought together consultants, physician residents, medical students and health

scholars who were struggling for public health reforms (Testa and Silva Paim, 2010; Silva Paim, 2002; Fleury, 2015). The *sanitarismo* movement opposed the Brazilian dictatorships, mainly by targeting the 'liberal neo-developmentalism,' challenging the authoritarian health policies, and the bureaucratic healthcare model of the regime. Sonia Fleury, professor and researcher at the *Fundación Oswaldo Cruz,* and former president of the CEBES, explained that the dictatorial model of healthcare included essential cuts to public expenditure on health, and the integration of private actors in the shift towards the free-market in the sector (2015). The *modus operandi* of the Brazilian dictatorship, Fleury continued, was primarily devoted to curative approaches that provided valuable financial returns through the set-up of high-cost services, and the deregulation of medical practices that favoured pharmaceutical companies and private insurance. This all set an ideal stage for the wave of neoliberal reforms that were emerging internationally.

The *sanitarismo* movement emerged during the peak of state violence in the 1970s through both the launch of the academic journal *Saude em Debate,* and the founding of its supporting institution the CEBES. During this time, Brazil experienced a prolonged crisis related to the developmental paradigms that had resulted from decades of misguided reforms, the international oil crises, and the progressive delegitimisation of the military dictatorship (Escorel, 1999; Escorel et al., 2005; Silva Paim, 2008a). Healthcare representatives "(…) mobilised in the face of a health-sector crisis expressed by the low effectiveness of medical care, the high costs of the medical-hospital model, and the low coverage of the services for population needs" (Silva Paim, 2008a:634; see also Arouca, 1975b). The movement was founded by highly-regarded leaders such as Sergio Arouca, Hesio Cordeiro, Mario Hamilton, Mario Testa, Sonia Fleury, and Emerson Merhy, who all constructed what became the Collective Health paradigm in Brazil.

According to Silva Paim (2012), the *sanitarismo* movement experienced great persecution under the dictatorship, characterised by the systematic closure of research centres, and the prohibition of gatherings organised by sectors that opposed the authoritarian regime. The tide turned in the early ‘80s when the crisis in the healthcare system became too evident to hide. "When the crisis arrived," Fleury commented, "the government realised the need to rationalise resources to sustain the healthcare system. And who did they call for that? The same group that criticised the system" (2015). Though this crisis created a window of opportunity to transform the system, the *sanitarismo* movement sought sanitary reforms that extended beyond the administrative provision of services

through the incorporation of health as a constitutional right. The new language envisioned by the Collective Health paradigm involved "(…) the expansion of the concept of healthcare, with the notion of healthcare as a 'human right,' as participation and as democracy" (Amarante et al., 2015:2025). The aspirations of assuming the 'right to health' as access to a healthcare system by the Brazilian *sanitarismo* SUS are best captured by Silva Paim:

> *"In 1977, an editorial in Saude em Debate…defended the idea of health as a 'right of every Brazilian' and indicated the 'need to organize the provision of healthcare services under a new perspective'… During the '70s and '80s, the growing social health movements proposed the democratisation of health, the state, and society … the proposition contemplated social concerns including ' the social determination processes of health and disease,' 'the organisation of health practices,' as well as notions like 'health awareness,' 'health promotion' and 'intersectionality.'" (2012:10).*

According to Silva Paim, the Brazilian sanitary reform must be understood not merely as changes in the provision of healthcare services by the SUS, but also as the embodiment of local struggles to improve living and working conditions – all within the scope of health as a constitutional right. Proponents understood the need to re-organise the national healthcare system by homogenising the services available, decentralising responsibilities, and universalising the coverage of care (see also Editorial 1977a, b). In this way, the *Sanitarista* movement anticipated a healthcare system that guaranteed services at the point of entry, was publicly-funded, available for all, free of financial obstacles, and directed by the state. Additionally, inspired by the European social medicine of the nineteenth-century, the *sanitarismo* 'right' as access to the SUS sought to provide additional tools that geared movements to tackle the social determination processes and appreciate broader emancipatory objectives (Silva, 1973; Fleury, 1989; Silva Paim, 2008a, b, 2012). "Sergio Arouca," Silva Paim explained, "guided everyone to a 'real health reform' involving economic and agrarian changes, as well as deep urban and financial reforms" (2012:11 see also Arouca, 1987).

During the 8th National Health Conference (Brazil, 1987), Arouca conceptualised health as a multidimensional field that required knowledge of population health status, the institutional response to healthcare needs, action upon the ideological milieu in a society, and the re-organisation of economic structures determining health. The first two dimensions corresponded to vital statistics and population surveillance, training of care professionals, equal and universal access to health services, and other administrative functions that the Brazilian SUS developed. The latter

two corresponded to the "(…) values, judgments, conceptions, and precepts that represent the symbolic and historical expression of our sanitary context", and the "(…) production, distribution and appropriation of wealth that determines the risk and possibilities in the health and disease process" (Arouca, 1988:2). Based on Arouca's perspective, health as the 'right' to access the SUS aimed to tackle capitalism in both the material basis of the socioeconomic model, *and* the mode of living reproduced by the dominant for-profit logic.

Image 6.1 Instalment of the 8th National Health Conference in 1986. Sergio Arouca among the panellist to open the event. Source: CCMS, 2016.

The distinctive definition of health as a constitutional right by the *Sanitarista* movement stems from the integration of perspectives that emerged from sectors like the Brazilian Communist Party, the Theology of Liberation, and different socialist unions in the healthcare sector. As Arouca explained (1988), the interpretation of health advocated by these groups as a 'right' in the '80s integrated concerns over the conditions of education, housing, sanitation, income, occupation, environment, and other matters related to the underlying societal structure. Access to the SUS in terms of rights is also encountered in other highly influential documents in the *Sanitarista* reforms, including the *Pelo Direito Universal à Saúde* (For the Universal 'right to health' in ABRASCO, 1985) and the *reflexões teóricas sobre democracia e reforma sanitária* (Theoretical reflection on democracy and health reforms, Fleury, 1989).

As Silva Paim commented, the *Sanitarista* constitutional mandate for health sought to redirect common-sense to consider and act on the historically-constructed conditions and power relations that impact well-being (2012:14). Given that the basis of the sanitary reform included the revolutionary aspirations and militant principles of the bottom-up initiatives of Brazilian social struggles, access to the SUS intended to advance a new civilising project that integrated the collectives into a political decision-making process in health – a process known as the 'democratisation of health.' Health as a constitutional right, therefore, "(…) incorporated population demands on health through a set of legal and institutional provisions, configuring different citizenships…and socio-political identities in the development of the political struggle" (Fleury, 1989:29). As explained by Fleury, the democratisation of health recognised the emerging social health movements as autonomous political subjects, capable of intersectoral transformations for the social revolution sought by social medicine. As a result, the establishment of the SUS model meant the embodiment of everyday struggles progressively assimilated in the ethos of state institutions. The organicity and potency of the reform then greatly depended on a connection with social movements and continued popular participation.

Fleury explained that the SUS model of the Brazilian sanitary reform involved a radical notion of public participation and democracy in health, represented by the *'Asambleas Permanentes'* (permanent assembly). Addressing the local experience of Montes Claros in the late 1970s[7], Fleury explained that the *Asambleas* consisted of "(…) daily discussions where everyone participated in equal conditions, from the financial sponsors coming from Washington to the maids from the local town serving the coffees" (2015). The permanent assemblies of Montes Claros had no technical instruments of deliverance and decision-making, no hierarchy among the people involved, and no particular organisation in the planning system. According to Fleury, deliberation was open to all, and decisions were made collectively and with mutual agreement, integrating top-level officials with the local population. "This was socialism to the fullest," Fleury commented, "(…) it consisted of the idea

[7] The experience of Montes Claros is a critical precursor of the unified healthcare system established in Brazil (Escorel, 1995; Fleury, 1995; Mayka, 2019). As Fleury explained, the Montes Claros initiative was a rare experiment, mounted during a temporary weakening of the military regime after the 1974 mock elections. The CEBES coupled with various international organisations to establish a local healthcare system with the municipal government of Montes Claros in the north of the country. The services covered all the population, free at the point of entry, and available regardless of income capacity. The planning of services and policies had a strong basis in public participation through the *Asambleas Permanentes.* The project attracted the attention of many political groups who opposed the regimen, generating a very unusual space of resistance within the context of state violence and high military repression.

of conquering hegemony before conquering the state apparatus of power. In other words, the goal was to win the common-sense of the population."

The Brazilian sanitary reform, therefore, envisioned the SUS model as an institutional strategy to transform the standing power relations within the Brazilian public sphere through democracy. To complete the endeavour, the *Sanitarista* movement conflated with the 'rights' discourse, presumably as the dominant and unavoidable language at the time that enabled the incorporation of social movements into the political decision-making process. As Fleury concluded: "The point was to find strategic points of entry into the structures of society which enabled the transformation of power dynamics without disarticulating from the social struggles and movements" (2015).

Although the Brazilian sanitary reform was conceived as a practice capable of achieving a progressive revolution in the mode of living, in reality the results were limited to the immediate transformation of the healthcare system alone. Rather than the emancipatory aspirations sought by the *Sanitarista's* 'right to health', the Brazilian SUS represented a 'passive revolution,' 'transformism' or 'partial reform' that enabled technical and administrative changes in the healthcare with no actual structural transformations or ideological shifts (Silva Paim, 2008a:633-634). In this way, it did not fulfil the promises made during the expansion of the collective health movements and health as a constitutional right in the 1980s. As Fleury wrote:

> *"The Sanitarista movement held the idea of occupying the state and participating in the spaces for democracy. But these attempts had many consequences. Many of our people left the movement to run the SUS. Yet, they subsequently lost the articulation with popular manifestations and the connection with social struggles, progressively becoming an institutionalised stance of political action with no teeth for big transformations…" (2015).*

Fleury presented a challenging context that determined the progression of the 'right to health' as access to the SUS after implementing the reforms throughout the 1990s. Brazil's socioeconomic circumstances at the end of the twentieth-century were characterised by free-trade agreements, the entry of markets in healthcare, austerity policies, and the precariousness of healthcare services that resulted from the neoliberal structural reforms in the region. The bundle of macroeconomic changes negatively impacted the management of social services, and severely restricted the fulfilment of governmental roles that *Sanitarista* members were appointed to in the unified

healthcare system. Ultimately, Fleury explained, the need to focus on the financial sustainability of the healthcare model drove the collective away from the real sufferings of the population, and articulation of the social struggles of dictatorial times. As she observed: “Weakened by an overwhelming bureaucracy, the collective health practices were eventually co-opted by the dominant capitalist powers.” The militant footing of the SUS model dissipated once the collective exchanged its closeness with social movements for the political effectiveness of the healthcare system.

Although the SUS model did not meet the goals and expectations of the *Sanitarista* ‘right to health,’ as a matter of professional ethics, the government officials dedicated their efforts as much as possible to defending the universal provision of services. The model still became a fundamental way to resist the wave of neoliberal reforms in the country "(…) otherwise, Brazil would have had a completely privatised system" (Fleury, 2015). Fleury's words, nevertheless, expressed a noticeable air of lament at the absence of a different political strategy from within the collective that could have achieved the democratisation of health in the way initially envisioned by the *Sanitarista* movement. For Silva Paim (2008a, b, 2012), confining the *Sanitarista* reform to changes in the delivery of healthcare services alone was also the result of multiple instances including government priority-setting, institutional obstacles, and changes within the *Sanitarista* movement, amongst others.

Alongside the establishment of the SUS in the late 1980s, the so-called 'emancipation of the SUS' emerged as "(…) the resistance against commodification and overemphasis in curative approaches that drenched the new system, in such way that technical practices were the only possible thing to do" (Fleury, 2015). In attempts to recover the political, ideological, and social basis of the 1980s *Sanitarista* movement, criticism grew within associations like the CEBES and ABRASCO. These were, nevertheless, either random pockets of dissidence that lacked the same weight as the original social movement, or an aggregation of voices that focused on securing the sustainability of the unified healthcare system (Silva Paim, 2008a). The responses against the limitations imposed on the Brazilian sanitary reform were not a thorough defence of the values and principles embodied by the *Sanitarista* constitutional mandate for health. In this way, access to the SUS progressively became a partial reform of institutional nature alone, vulnerable to political manipulation, empty of the mobilisation character, and incapable of producing changes in the social order. The *Sanitarista*

reform, Silva Paim continued, progressively lost space in the governmental agenda, and was not considered central in the sanitary movements of subsequent years (2008a). Through the progressive compromising of social and political bases for reform, the 'right to health' became vulnerable to disfigurement, and was reduced to its administrative, institutional and sectorial scope (see also Rodrigues, 1999) – as witnessed by the HIV/AIDS epidemic in Brazil.

Image 6.2 Dr. Sonia Fleury speaking at the Inaugural talk for the 20th cohort in the Masters of Epidemiology, Managements and Politics in Health at the Institute of Collective Health, Universidad Nacional de Lanus. Conference titled "The Challenges in Construction Citizen's Democracy." To her right, former ALAMES Argentina representative Dr. Hugo Spinelli. Source: Fleury, 2017

By the end of the twentieth-century, the application of the 'right to health' in Brazil focused on access to medication claimed by the HIV/AIDS movement in the country, echoing events already advancing at the global health level. Documented initially in South Africa (Olesen, 2006; Gloppen, 2008), the development of new antiretroviral drugs for HIV/AIDS prompted a unique partnership between grassroots movements, politicians, local entrepreneurs, and the media advocating for access. As part of the patency laws of the World Trade Organisation, the antiretrovirals were subject to a monopoly by the pharmaceutical companies to guarantee the financial return that justified the

investment in research, equipment, and other resources. However, this monopoly created a global asymmetry in access to medication because benefits were restricted to Western European and North American countries, while the vast majority of the developing world had to wait over a decade before they could afford the high prices. Olesen explained: "Public opinion expressed indignation over the apparent greed of pharmaceutical companies in a situation where millions of lives could be saved" (2006:7). The popular upheavals and massive local campaigns led the case to national and international courts, crafting the 'right to health' as a legal argument for individuals to access drugs for the first time, and making headlines globally due to the political, ethical, and financial implications of the challenge patency laws.

In the case of Brazil, the HIV/AIDS patients association in the 1990s used the constitutional mandate towards health introduced by the *Sanitarista* efforts in the previous decade (Fleury and Mafort, 2001:13), transforming its meaning from access to the SUS, to access to pharmaceuticals. The movement filed multiple lawsuits demanding the state to guarantee the 'right' to access antiretroviral drugs (Petryna, 2009b; Biehl et al., 2009; Bielh, 2013). The success of local activism came by way of a law in 1996 that established free universal delivery of medication to HIV-infected patients. Antiretroviral drugs were subsequently added to the essential list of medicines provided by the government as part of the SUS (Galvao, 2002, 2005; Berkman et al., 2005; Biehl, 2007b). The measures were later reaffirmed and expanded into a national programme for HIV/AIDS, proposed by the Ministry of Health and ruled by the Federal Supreme Court as part of the fulfilment of the 'right to health' in the constitution (STF, 2000). The benefits of the new legal framework on antiretrovirals included importing generic drugs from thriving industries abroad, the production of generics in local laboratories, and a strong regulation of drug prices. The SUS, moreover, provided the ideal infrastructure to support the new measures, given its mandate of universal coverage and free of cost (Porto et al., 2011). So, by accessing medications through statutory mandates, human rights activists were viewed as having accomplished a significant victory for the poor, as well as against transnational corporations for the first time in contemporary Latin American history.

Though the paradigmatic HIV/AIDS programme in Brazil became highly regarded globally, the lawsuits transformed the *Sanitarista's* 'right to health' from the democratisation intended by the SUS to institutional mandates to access medications through national courts (Motta, 2013:4). In this way, rather than the comprehensive action on the structures of society, and awareness by the

general population; most of the success stories of the SUS revolve around top-down national programmes that secured treatment and technologies – also known as 'judicialisation of health' (Biehl et al, 2009; Biehl, 2013). As a result, the HIV-AIDS national programme differed significantly from the socialist-inspired revolution sought by the *Sanitarista* movement through the SUS model. As various authors explained (Petryna, 2009b; Motta, 2013; Reubi, 2013), through the success of the Federal antiretroviral programmes, the 'right to health' litigation in Brazil grew exponentially into new and high-cost health technology for rare diseases, experimental therapies, and novel interventions. In this way, the process of judicialisation accomplished: (i) the endorsement of the 'pharmaceuticalisation of public health', through which health is interpreted in biomedical terms alone, and (ii) an overemphasis on individual claims to access specialised and expensive drugs at the expense of broader population health programmes that covered chronic diseases, long-term care, and strategic preventive measures, such as vaccination or screening. The 'right to health' as access to medicines in Brazil, therefore, fed into the growing pharmaceutical free-market, the international patency laws, and the partial reform of the local SUS during the late twentieth-century.

While access to drugs may be considered a necessary move by social movements to tackle the early problems in the SUS (including the neoliberal minimisation of the state), a decrease in funding to local healthcare system resulted, along with difficult access to healthcare in the periphery. As Biehl wrote: "(…) Many citizens go to local public pharmacies only to find that basic medicines are out of stock and that the newer medicines are not included in official formularies" (2013:421). Adriana Petryna also described several commentaries on patients undergoing legal processes for accessing healthcare, describing the struggle as a necessary 'fight' against local corruption, in which politicians deviated massive public health resources to fulfil their greed (2009a). Additionally, other ALAMES members in countries like Colombia have also documented that the need to maintain legal alternatives for access to medication across Latin America led to multiple financial obstacles for satisfying healthcare needs. For instance, authors highlighted the systematic denial of essential care by healthcare insurance companies across the country, creating the phenomenon of *'paseo de la muerte*' or 'death ride' where patients are forced to an endless journey of bureaucratic permissions to acquire the services they need (Hernandez, 2000; Abadia-Barrero and Oviedo, 2009; Hernandez and Torres, 2010; Sanchez-Vanegas et al., 2013; Abadia-Barrero, 2016). The 'right to health' as access to pharmaceuticals in Latin America, therefore, provided a judiciary solution for patients

when confronting an ill-equipped system, scarcity of resources, and questionable governance in healthcare - but at the cost of broader societal transformations.

Despite the advantages found when the access to drugs was framed in terms of 'rights,' the judicialisation of health has been extensively challenged across the literature (Byrne, 2009; Gauri and Brinks, 2008; Hogerzeil et al., 2006; Yamin and Parra-Vera, 2010). A comprehensive analysis of these challenges extends beyond the scope of this chapter. However, the revision of some aspects is pivotal for the definition of 'right to health', and its association with the healthcare system model according to ALAMES (found in the next section).

First, the 'right to health' as access to medications devotes attention to therapeutic approaches like pharmaceuticals and technologies, while neglecting the social processes involved in population health and disease. According to Biehl, "(…) Increasing reliance on pharmaceuticals and treatment has gone hand-in-hand with the growing dominance of biomedical epistemology" (2013:425). The establishment of health litigation developed roles that intersected the judiciary, the free-market and biomedical practices. As Biehl explained, courts become pharmacies, lawyers acted as physicians, patients' associations worked as legal counsellors, and physicians were transformed into activists. Most importantly, the infiltration of market principles into the health sector has led patients to become 'rational choice-making economic subjects' in need of consuming emerging technoscience as a question of legal rights (Bielh, 2013:421). As a result, pharmaceutical corporations have become pivotal in the advancement of neoliberal states across Latin America, reaping benefits from the 'right to health' litigation. "Drug firms," Petryna added, "capitalising on the idea of citizen empowerment, have used the progressive human rights instrument as a way of disseminating their product" (2009b:147). Pharmaceutical corporations finances various patient groups to direct the individual 'right to health' claims to expensive new alternatives offered by these companies. As long as the cases succeeded – that corresponded to the majority of the litigations in Brazil (Bielh et al., 2012) – governments were obliged to purchase from transnational corporations at the established price, despite questionable clinical efficiency in many instances (see also Ramos, 2005).

Second, as mentioned earlier, the overemphasis on individual claims for medical interventions diverted public funds from broader societal approaches such as preventive health programmes,

national disease-centred programmes, and the financial sustainability of the unified healthcare system. As Petryna explained: "The availability of and access to high-cost drugs has prompted the government to rethink its drug-purchasing policies and rationalize their use" (2009a:147). For Petryna, the triumph of the 'right to health' as access to drugs opened a 'floodgate' to universalising high-cost medication to a well-connected portion of the population, at the expense of essential medicine programmes for the broader community. The new dynamic placed individual claims in tension with population needs, as both competed for the allocation of scarce resources. During the first lustrum of the millennium, for example, the Brazilian SUS allocated roughly 8% of its budget to provide exceptional treatment for individual claims, decreasing the funds of other federal healthcare programmes proportionally (Messeder, 2005 in Petryna, 2009a). The critical difficulties in facing these challenges prompted Latin American governments to create local guidelines that standardised clinical practices, guiding physician prescription to drug-cost containment, based on evidence-based medicine. Petryna's research on pharmaceuticals research in Brazil elaborated on the advancement of regional approaches to health technology assessment during the Lula government, with the emergence of apparatuses like the Centres of Reference, clinical protocols, and market strategies (Petryna, 2009b, 2011; Reubi, 2011). However, the systematic application of guidelines and the establishment of health technology assessment institutions in the region remains a work in progress.

Lastly, authors also highlighted that the 'right to health' as access to medicine negatively impacted health equity, despite the potential benefits of acquiring denied or neglected services. Even after the new constitution, the inequalities in health have grown in Brazil's society, leading to the idea of 'two Brazils' so disparate that opposite socioeconomic communities share the same territory next to each other. Though the health litigation may have helped to implement constitutional promises, "(…) one must be aware that the opposite is also possible, that is, that courts may be able to achieve little to no change or, worse, might further hinder the transformative enterprise" (Motta, 2013:2-3). Motta's research points to a sceptical stance against the litigation of health, as the high success of individual claims disproportionate benefits enjoyed by the better-off. As Biehl and colleagues document (2012), high-income patients are more likely to acquire expensive medication in contrast to those on low-incomes, whose claims are mostly referred to services already included in the essential packages of the healthcare system. The findings suggest that the problem with the 'right to health' as access to medicine is not merely the claims granted, but also a fundamental flaw in the

government's resource distribution system. Until the Brazilian political sector comprehensively changes the public health sector, the inequalities developing from the 'right to health' will reinforce the need to maintain the interpretation of this right as judicialisation of services.

III. ALAMES' UNIFIED HEALTHCARE SYSTEM OR SUS:

The unified ALAMES healthcare system or SUS is a comprehensive political project that built on an institutional transformation of the healthcare system to guarantee the universal provision of healthcare services, and bring about the collective's emancipatory objectives. Similar to the *Sanitarista* movement, ALAMES defined the 'right to health' as access to the SUS, and used the discourse as a strategy to achieve the democratisation of health. The merging of SUS with the 'right to health', nevertheless, came about during the 1990s and 2000s. This was presumably in the aftermath of the demise of belligerent efforts by radical left-wing groups across the continent, and again, which the Brazilian *Sanitarista* illustrated.

As explained in the previous section, the *Sanitarista* 'right to health' embodied the Brazilian left-wing political and intellectual goal to embrace democratic means and institutional governance in order to achieve societal transformation. However, the proposition of a revolution through democratic efforts did not go well with the communist orthodoxy in Latin America. "At the 6th Brazilian general meeting of the communist party, we (*Sanitaristas*) decided to commit to the health struggles through democratic means. This wreaked havoc in the collective and fragmented the party greatly," Fleury explained (2015). In the 1970s, when Latin American socialist politics leaned towards armed resistance against capitalist dominance, the Brazilian *Sanitarista* reforms resulted in the rupture of local dissidents from the regional left-wing struggles. The importance of this rupture was that, once the *guerrillero* movements lost the weight of legitimacy and influence at the turn of the century, many of the armed members of these groups adopted the pathway of social transformation through democracy by joining organizations like ALAMES (see also Merhy, 2015). Chapter three explored cases of such shifts through the biographical narratives of ALAMES members Eduardo Espinosa, and Nila Heredia. In the change towards democracy and health, Latin American social medicine adopted the interpretation of 'right to health' as access to the SUS, strengthening the

institutional approach for the ALAMES collective until contemporary times. Dr Mario Hernandez, director of the Public Health postgraduate research programme at the Universidad Nacional de Colombia and former ALAMES general coordinator, provided an entry point to the ALAMES healthcare model with the following statement:

> *"Health is a human right and a common good which the state must guarantee through a healthcare model. The only way to realise a healthcare system that is unified, public, decentralised and lacking any restriction to access; is to decommercialise and demarketise medical services" (2017)*

According to Hernandez, the systematic integration of a unified healthcare system in terms of 'rights' in Latin American social medicine did not extend beyond the Brazilian context until the early 2000s. The integration of the 'rights' language at ALAMES resulted from two catalysing events in the thought style: (i) the commodification of healthcare services by the macroeconomic reforms of the 90s, and (ii) the interpretation of health as a collective 'right' used to resist the advances of neoliberalism.

Firstly, according to various ALAMES members, the macroeconomic or neoliberal reforms in Latin America created the so-called 'crisis of civilisation' at the end of the twentieth-century (Feo, 2014; Uzcátegui, 2014a; Rovere and Gonzales, 2018). Particularly in the field of healthcare, Hernandez argued that the entry of market principles in health came by way of the so-called *managed-care model* (Enthoven, 1988; Waitzkin, 2011) or *structural pluralism* (Londoño and Frenk, 1997; Frenk, 2015). *Structural pluralism* is a healthcare model that secures the financial protection of the population against catastrophic health costs by relying on the administrative efficiency of insurance companies. These companies pool funds from the population either through taxation policies or monthly premiums, and function as intermediaries between the public budget and the healthcare providers.

According to Hernandez, Latin American governments established comprehensive neoliberal reforms in the 1990s that were bound to obtaining loans from international financial organisations, including the World Bank (WB), the International Monetary Fund (IMF) and the Inter-American Development Bank (IADP). Maintaining a discourse of 'development' and 'progress,' these financial institutions secured conditions for the loans to be implemented as neoliberal systems of social

security nets, including the *structural pluralism* in healthcare. Hernandez highlighted that the Londoño and Frenk model of healthcare, sponsored by the WHO and PAHO, came to be known in Latin American social medicine as *Cobertura Universal de la Salud* (CUS or Universal Health Coverage in Spanish). Hernandez described how the neoliberal model introduced free-market competition in healthcare by reframing medical services and resources as commodities that could be bought and sold, based on the logic of supply-demand, reaping significant profits. The CUS focused on the management of financial risks that the high-cost healthcare system produced, while protecting the capitalist model that created the high costs in the first place.

The ALAMES collective opposes the CUS model because it used the 'right to health' as a smokescreen for the privatisation of healthcare (Almeida-Filho, 2014; Laurell, 2011b; Waitzkin, 2011). Oscar Feo, former ALAMES general coordinator and professor of public health at the University of Carabobo in Venezuela, stated: "It is clear that there is a confrontation between health conceived as a commodity and consuming good and health conceived as a right" (2014). For Feo, the current struggle of health movements in Latin America involved a 'dispute for the discourse', whereby actors subordinated to the global capital in healthcare, including the WB and the WHO, appropriated and distorted foundational concepts that belonged to Latin American social medicine. The most important of these concepts was the 'right to health'. Feo stated: "(the WB) promotes universal healthcare coverage as an issue of the 'right to health', but in reality they intend to implement the business of market insurance in healthcare masked as universal coverage" (2014; see also Feo, 2018e). Feo argued that financial actors co-opted and reframed the universalisation of services to fit their purpose of pharmaceuticalisation of public health, and reap the benefits of government-secured markets.

Secondly, before the neoliberal reforms, most members of ALAMES remained apprehensive about any type of human rights approach, due to the proximity of the framework to liberal ideals. As Stolkiner explained elsewhere, the 'rights' discourse embodied a paradox: on one side, 'rights' may be presented as tools of dominance for contemporary advanced capitalism; on the other side, 'rights' may also be the means to transform society towards a new arrangement of power relations (2010). As tools of dominance, Stolkiner explained: "At the beginning, the 'individual civil rights'… held the potentiality of excluding certain forms of life despite the discourse of universality" (2010:90). For many ALAMES members, certain strands of human rights, particularly the so-called

‘individual civil rights ratified’ by the International Covenant on Political and Civil Rights (1966), ignored various groups that did not abide by the western model of capitalism: a modern, white, bourgeoisie male owning valuable assets, and demanding protection and liberties (Raffin, 2006).

According to Stolkiner, the idea of individual entitlements typical of US politics obstructed the development of collective rights by generalising the western notion of autonomy, and enshrining liberal values like independence and individualism. The ‘right to health’ as access to medicine follows the individualist interpretation of entitlements by limiting the scope of rights to legally support the commodification of medical practices. Stolkiner explains that lawsuits which provide medications and services seek to accomplish an individualist sense of ‘rights’ at the expense of a broader social justice. While on one side, the health litigations satisfied individual claims to high-cost drugs, on the other, judicialisation neglect the struggles of emancipatory movements against ethnic disparities, gender asymmetries, labour oppression, and health inequities. Through the pharmaceuticalisation of public health, the individual suffered what Stolkiner called the ‘objectification’ of life, by transforming health needs into a tradable good that simplified inequities to technical questions solved by biomedicine.

As a means for transformation, nevertheless, the ‘rights’ discourse offers a different interpretation to entitlements that is functional for the social medicine collective. The International Covenant of Economic, Social and Cultural Rights in 1966 (never ratified by the US government), differed from the ‘individual civil rights’ above as the alternative rights framework includes “(…) the minimal level of economic well-being and the security to participate in social affairs…institutionally corresponding, in summary, to the educational system and social protection nets” (Fleury and Mafort, 2001:4). These ‘social rights’ were ratified in the late 1970s by the WHO Declaration of Alma-Ata on primary healthcare, and the commitment to 'Health for All' conceived as horizontal approaches focusing on public participation, community healthcare, and the integration of rural populations (Gaudilliere and Beaudevin, 2020). Based on these legal frameworks, Stolkiner explained that the introduction of social rights at a global level in the second half of the twentieth-century enabled the emancipatory possibility of recognising diversity, egalitarianism and multiculturality interculturality – features that were pivotal for Latin American social medicine, and which enabled the integration of ‘rights’ into the thought style.

In practice, the ALAMES idea of access to comprehensive healthcare in the 1980s was not framed in terms of 'rights', but was predominately a concern of social solidarity, state policies, and social protection. Only in the late 1990s did the ALAMES begin integrating 'social rights' to point at the access to the SUS model and the social transformation through democratic means. This was after events such as the crisis of welfarist governments, the fall of the USSR, the attack on public management, the externally imposed structural reforms (taking advantage of the debt crisis), and the emergence of the judicialisation of health, among others. For many, the 'rights' discourse was the only possible means to maintain any sort of resistance amidst the most unfavourable political arena towards left-wing politics to date. As former ALAMES General Coordinator Rafael Gonzales explained: "With the fall of the Soviet Bloc and rise of Neoliberalism, we faced the most difficult time ever – it was really difficult moment for social medicine…We couldn't digest or make sense of the fall of socialism!" (2018b). According to Gonzales, social medicine at the time was structured around the socialist proposition of the USSR, China and Cuba. Once the Soviet Bloc fell, the left fell into international turmoil with the collective in Latin America 'abandoned' and unable to 'reconstruct' political propositions.

In order to remain politically relevant and resist the overwhelming advances of economic orthodoxy, Gonzales concluded, it was necessary for the collective health movement to take up certain discourses previously criticized within ALAMES but highly functional during the decadent times. These included issues such as the idea of citizenship (Fleury, 1994) and, most relevant for the current chapter, the 'right to health' (Torres and Paredes, 2005a). Social rights challenged the disproportionate tendency to satisfy the individual 'right' to access medications at the expense of the broader society, which was a contribution instrumental for the 90s ALAMES. Ultimately, nevertheless, though the fulfilment of individual claims may be justified in instances of denied services, "(…) if the rights of any other person are not secure, but my rights are - then my rights are no longer entitlements but become privileges" (Stolkiner, 2014).

The emancipatory potential of the 'right to health' as access to the SUS according to ALAMES is seen in the social medicine approach to resist the capitalist tendency to interpret health in terms of biomedicine alone. "The recognition of the 'right to health' based in the complex conception of the health and disease process", Stolkiner explained, "requires integral policies that also protects against the medicalisation of life" (2010:92). Stolkiner understood the 'right to health' as the critique

against modern forms of social control, based on biomedical thinking that obscured the analysis of economic, political and social processes impacting health (see Scheper-Hughes, 1993; Conrad, 2007; Davis, 2009; Conrad et al., 2010). The 'right to health' for social medicine, integrated after the neoliberal reforms, was interpreted as an endeavour that benefited all collectives through political policies that encompass equally the questions of healthcare and the actions on the social determinants of health. This view certainly aligned with the WHO's Universal Health Coverage, the UN Special Rapporteur on the 'right to health', and the General Comment 14; by holding foundational the provision of medical services for all through a shared pool of funds, the state was required to protect individuals against the catastrophic crash of current healthcare market costs (UN-CESC, 2000; Savedoff et al., 2012; Moreno and Smith, 2012; Lagomarsino et al., 2012). However, ALAMES remained sceptical of the WHO/UN approach, as it considered the organizations as sponsoring the CUS lucrative goals and privatisation (Waitzkin, 2011; Heredia, 2013; Feo, 2014).

During a panel discussion at the XV International ALAMES Conference in Bolivia titled "The Construction of the SUS," Hernandez explained the intermediary function of the CUS insurance companies in more depth (2018b). According to Hernandez, insurance companies guaranteed the provision of healthcare coverage based on the individual capacity to contribute to the financial pool. They basically created a fragmented system with differential coverage plans according to social class. These coverage plans included: (i) the private package, corresponding to the highest quality services and infrastructure for the high-earning class, who were rarely denied services or access to new technologies; (ii) the mandatory package, targeted to the bulk of the population who could contribute to the shared funds that provided average quality of care with various access restrictions; and (iii) a subsidiary coverage for the poor who could not pay, that provided only essential medicines deemed appropriate for the population's epidemiological needs.

For Laurell (2018a), the fragmented coverage described above was a bureaucratic move that kept the abandonment of the most vulnerable hidden. Each coverage plan, Laurell explained, provided a specific bundle of medical services tailored to the financial contribution of the individual. Rather than meeting the needs of the population, the fragmentation of the CUS reinforced inequalities in healthcare as the healthcare provisions diminished proportionally to the decrease in income capacities. As Hernandez explained elsewhere (2017), the less the individual contributed, the greater the limitations in accessing healthcare. Hence, the progression of illness in individuals largely

depended on which tier the patient belonged to. For instance, all adult patients with diseases of high prevalence - such as Diabetes Type II, hypertension or hypothyroidism – would receive the necessary treatment, regardless of the coverage plan. However, if a lower-class individual acquired diabetes that quickly developed into heart failure, they may be eligible for treatment of the underlying disease, but not necessarily for the consequences that require more specialised interventions. In such circumstances, Hernandez concluded, highly specialised interventions would be denied or neglected by the CUS according to the coverage plan, requiring out-of-pocket expenses in order to pay for the additional treatment – to the detriment of the poor.

Image 6.3 Questions and Answers session during the Conference proceeding entitled: "Universal Healthcare Systems: Obstacles and Challenges" at the South American Institute of Health Government, 2014. From left to right, Dr. Oscar Feo (ALAMES Venezuela) and Dr. Asa Cristina Laurell (ALAMES Mexico), both former ALAMES General Coordinators. Source: Laurell, 2014a

Various ALAMES members questioned the motivation driving the CUS to establish the distinct packages of services (Heredia, 2013; Abadia-Barrero, 2016; Rovere, 2019). Rather than protecting the healthcare system against a backdrop of scarce resources, Feo linked the fragmentation to the lucrative goals of private actors (2014). He suggested these service packages originated as a counter-

response that major financial groups constructed against the WHO Alma-Ata declaration (and, therefore, the idea of 'social rights'). Promoted by the Rockefeller Foundation, various healthcare financial groups met at the Bellagio Centre in 1979 to devise an approach that would limit the comprehensive transformation of society defended by the primary healthcare strategy of Alma-Ata. According to Feo, the Bellagio group agreed to restrict the socialist ideas of the 'right to health' to a bundle of services feasible to acquire and manage at the level of the growing global healthcare market. In this way, Feo stated that the CUS was 'universality reduced to its minimal expression', and aimed at the establishment of market principles without losing the concepts that enabled the expansion of business coverage in health. Mario Rovere, former ALAMES general coordinator and professor of public health at the Universidad de Lanus in Argentina, added:

> *"The CUS is the systematic construction of minimal packages of services for all… (For the CUS) the private sector provides the complex services, and the government remains in charge of a very selective bundle of essential interventions…The selective bundle of services is termed 'low-cost.' That is to say, the neoliberal model is 'low-cost primary healthcare for all'" (Rovere, 2019)*

Along with Hernandez, Rovere considered the CUS hierarchical system as an approach that deepened social inequalities by enabling the accumulation of wealth for specific sectors of society. On the one hand, Rovere connected the denial and neglect of services according to income capabilities as nudging patients to acquire complementary packages, bought from private entities. Though individuals may not be able to afford these packages, the rising phenomenon of judicialisation of health, as explored in the last section, forced governments to provide the services denied as a matter of fulfilling the constitutional mandates. Following the pharmaceuticalisation of public health, the heavy dependence on medical interventions, and the rising costs of services progressively increased the government's overall expenditure on health, benefiting pharmaceutical companies and insurance corporations. Additionally, as per Laurell (2014b), the CUS established diverse strategies to restrict healthcare access further, including fees on top of the contributions made to the system. These increasing restrictions created what elsewhere Laurell termed the "conflict of intentions" (2018a) – a tension between the conditioned access the CUS offered, and the 'right to health' as the state-sponsored provision of services.

On the other hand, the CUS profit-making strategies were also found in the change of labour contracts imposed by the privatisation of healthcare. As Feo argued, the entry of private actors created the so-called 'proletarization of doctors' through which employment social benefits and permanent jobs were replaced by precarious service-provision contracts (Feo, 2018e; see also Waitzkin, 2018b; Anderson, 2018). In practice, the new contracts translated into a loss of social security nets provided by employers, and the proliferation of labour uncertainty, all to reduce costs for companies. The lack of effective accountability on labour dynamics, typical of the Latin American context, also caused severe delays in salary payments, and the inadequate provision of resources to fulfil healthcare roles. Additionally, Feo continued, some countries in Latin America also enabled an accumulation of wealth for the insurance companies through the intermediary function of public funds administration – either by the illicit deviation of resources or the intentional rise in administrative costs to increase stakeholders' value (see also Hernandez, 2002).

The ALAMES SUS model guaranteed *universal coverage* not by affiliation to an insurance company or a dependency on financial capacity, but by being born into the national citizenship of a given country (Laurel, 2018a; Heredia, 2013). Contrasting the neoliberal approach, the SUS model openly discarded market principles in healthcare by grounding the provision of services exclusively by the state, shielding against capitalist competition and strengthening public infrastructure. Eduardo Espinosa, current ALAMES general coordinator and former Health Minister of El Salvador, explained that the foundational element in the SUS model was the merging of the 'right to health' guaranteed by the state, rejecting the admission of private actors to the provision of services. According to this view, the government fulfilled all roles associated with healthcare without differential packages of services or fragmentation of coverage.

Public institutions are responsible for pooling the health budget from the various tax policies and financial contributions. The SUS aligned with the single-payer national health programme advocated by other ALAMES members, whereby financial contributions were pooled into a single public programme for the national distribution of medical resources (see Rovere, 2019; Waitzkin and Hellander, 2018). In this way, the ALAMES healthcare system aimed to have no additional out-of-pocket payment or co-payments for services provided, focusing the unified healthcare system solely on the financial protection of individuals against catastrophic healthcare expenditure. Following from the previous point, the SUS also sponsored the state's responsibility for the provision of

services by strengthening public healthcare institutions, securing medical resources, and formalising healthcare personnel (Gonzalez, 2018d). All of the infrastructure, services and resources related to the provision of healthcare was, therefore, entirely an issue of government administration. Lastly, according to Laurell (2014a), an additional strength of the SUS model was the capacity for strategic planning of national health policies beyond the healthcare system in the fulfilment of the 'right to health', with the integration of broader societal processes. Laurell explained that the unified nature of the SUS offered the possibility of tackling other social determinants of health, such as education, income, occupation, living, and working conditions. The centralised capacity to settle priorities by recognising the vulnerabilities of certain territories enabled the SUS to cooperate with other sectors of political governance for population well-being. The cooperation among the sectors corresponded to the fundamental observation that the 'right to health' could not be understood in healthcare terms alone (Heredia, 2013; Uzcátegui, 2014a, b).

Nevertheless, Laurell argued that, given the limitation of resources in healthcare budgets, the comprehensive provision of services could not be met immediately, but followed a gradual process (2014b). The SUS proposition for achieving equal access to medical services in a nation-state according to needs, consequently, met several challenges that were not addressed comprehensively by the ALAMES collective. Mainly, the collective does not propose feasible solutions to secure the proper management of funds, despite the recognition that Latin American countries lack the proper institutional capacities for efficient accountability and social control of governmental affairs (Gonzales et al., 2014; Espinosa, 2018b). Moreover, the increase of healthcare costs globally places governments in conflict with a network of international actors and frameworks, including financial organisations, intergovernmental agreements, pharmaceutical corporations, biomedical research centres, and insurance companies. The local versus global tension calls for a set of political and legal measures that considered health technology assessment, cost-benefit analysis, local clinical guidelines, regulatory drug tariffs, and local production of generic medications, amongst others. These are measures not amply discussed in the Latin American social medicine literature.

Likened to the *Sanitarista* movement, another prominent objective of the ALAMES SUS model is the transformation of the material and symbolic basis of contemporary capitalist society. As explained in previous chapters, the material basis corresponds to the basic requirements of healthy living, including proper sanitation, adequate housing, wholesome nutrition, and the guarantee of a healthy

environment (Heredia, 2013). The symbolic basis refers to the integration of a newly-emerging political subject from social movements and struggles on the determination of everyday affairs, in a move towards radical and direct democracy or the self-governance of communities (Espinosa, 2019). As such, the social medicine approach to healthcare also aims at the "(…) the empowerment and popular participation of communities" (Feo, 2014; Silva Paim and Almeida-Filho, 1998) as a fundamental principle for the radical transformation of society. Feo argued that, rather than stripping the state of its administrative capacities, the SUS integrated state responsibility with population efforts in management, protection, and maintenance of the healthcare system.

On the same note, Uzcátegui framed the SUS motto as: "We support a unified, national and public healthcare system with state responsibility for the sector and the participation of the population towards collective health and the Buen Vivir" (2014a). For the Venezuelan academic and former coordinator of the ALAMES Latin American Network of Organisations and Social Movements for the 'Right to Health', the very foundation of the unified healthcare system was not a guarantee of healthcare privileges to the population. Instead, Uzcátegui continued, the mandate was to grant individuals and communities the capacity to defend and maintain their sovereignty, aligning considerably with the democratisation of health of the *Sanitarista* movement. Uzcátegui argued for a bottom-up approach in the SUS where the 'right' to access services and act upon the social determination of health was not a plea to the government, but was instead taken as a matter of collective governance and autonomy. Following the Zapatista movement, Uzcátegui concluded that the ALAMES SUS sustained a spirit of self-determination following the motto: "(…) in this territory - the people rule, and the government obeys" (2014a).

The *Comision Intersectorial de Salud* (Intersectoral Health Commission) – a fundamental space for democratic deliberation in the SUS systems of El Salvador (Espinoza, 2019; Posada, 2017) – was a paradigmatic case of popular participation, empowerment and radical democracy in the application of SUS by ALAMES representatives. According to Espinoza, the health commission gathered more than 40 governmental and non-governmental organisations from the private and public sectors. Following the same dynamic as the *Asambleas Permanentes*, Espinoza commented: "(…), the discussion of intersectoral concerns at the commission results in fundamental inputs for the formulation of national policies and execution of health programmes" (2019). The CIS represented a new institution that sought to integrate the population, shaping the ethos and transforming the

subjectivities to actions on social determination processes. In this way, the SUS model of ALAMES was presented as the 'right to health' of the population in order to accomplish radical social transformation.

Image 6.4 Conference proceeding titled "De-estabilisation of the Progressist Governments in Latin America" at the Universidad de El Salvador, 2016. From right to left, Dr. Mario Rovere, Dr. Jaime Breilh, Margarita Posada (ALAMES El Salvador and leader of the Intersectoral Health Commission), Dr. Oscar Feo. Source: UISP El Salvador, 2016.

IV. THE HISTORICITY OF THE SUS IN LATIN AMERICAN SOCIAL MEDICINE:

a) BETWEEN MILITANCY PRINCIPLES AND POLITICAL PRACTICE:

Similar to the Brazilian sanitary reform, despite the ALAMES integration of access to the SUS in terms of 'rights' during the late 1990s, the approach has not been applied nor developed at national level for several reasons. Put differently, though the unified healthcare system intended to be a democratisation of public health alongside a practical approach against its 'pharmaceuticalisation,' the model transformed from a revolutionary strategy to a partial reform of the provision of services

once the SUS was placed into practice throughout Latin America. The failure to materialise the political goals of the right to health as SUS largely resulted into a deep sense of disappointment and frustration within the collective, noticeable at the XV ALAMES International Conference in Bolivia. The contextualisation of this conflict is as follows.

During the first decade of the new millennium, a transformative wave of left-wing politics swept through the region in the so-called *progresismo* governments or the Latin American twenty-first century socialism. The *progresismo* presidents included Lula da Silva in Brazil, Hugo Chávez Frias in Venezuela, the Kirchners in Argentina, Evo Morales in Bolivia, Rafael Correa in Ecuador, Fernando Lugo in Paraguay, 'Pepe' Mujica in Uruguay, amongst others. Initially, *progresismo* incorporated the collective health movement by assigning ALAMES members to governmental posts including health ministries, chairs of national institutions and local welfare secretaries. The new posts provided an ideal opportunity for ALAMES officials to apply the SUS model in healthcare. However, echoing the *Sanitarista* movement, the national offices did not realise the comprehensive extent of social transformation the SUS required. Instead, officials were primarily devoted to the optimisation of healthcare delivery against a backdrop of austerity policies that curtailed state services, sustaining the on-going cutbacks in welfare benefits. Therefore, rather than a successful attempt to move away from the overly theoretical approach in Latin American social medicine, the 'right to health' as access to the SUS did not progress once militancy was placed into political practice.

Though the strategies of the *progresismo* governments only matched a fraction of the social medicine SUS model, even these advancements experienced significant setbacks after the demise of the twenty-first century Latin American socialism in subsequent democratic elections. The elections immediately Following the end of left-wing presidential terms in the region, countries experience a renewed rise of neoliberal administrations including Jair Bolsonaro in Brazil, Lenin Moreno in Ecuador, Mauricio Macri in Argentina, Nayib Bukele in El Salvador, etc. Various ALAMES members interpreted the abrupt change in politics as the 'failure' of socialist movements to trump the dominant capitalist ethos across Latin America (Rovere and Gonzales, 2018). A prominent example of this phenomenon is found in the political development of El Salvador in recent decades. During a morning session at XV ALAMES International Conference in Bolivia, Ricardo Santamaria, a member of the Salvador Allende movement, El Salvador ALAMES representative, and prominent voice in the RED-LOMSODES node, commented in apparent indignation:

"It should not be possible that a left-wing government in El Salvador takes away the rights of the people in attempts to fit the budget constraints – when the resilience of the worker's struggle in the streets achieved these rights. It cannot be possible to have this threat against our well-being when the economic model that generated the constraints in the first place has remained mostly unaltered." (2018)

Gifted with a booming voice and charismatic personality, Santamaria raised interesting questions regarding the factual continuity of militancy principles once members of ALAMES reached governmental posts. Following Espinosa's narrative from chapter three, the former guerrilla group *Frente Farabundo Marti para la Liberación Nacional* (FMLN) was elected to the presidency at El Salvador's 2009 elections. According to Santamaria, the triumph of the left-wing political party resulted mainly from the support of social movements and grassroots initiatives that built a network of political activism in the country. The reforms established by the FMLN government followed the directives of popular demands and were undoubtedly a great success. These included an increase in hospital infrastructure, the doubling of primary healthcare centres in rural areas, the optimisation of employment rates, and the strengthening of human resources. Many at the conference looked up to El Salvador for these reasons.

Nevertheless, Santamaria explained that the incoherencies of the FMLN political elite disabled the progress of a radical transformation of society by casting questions on whether the ultimate goal was the strengthening of the social movements that favoured the *progresismo* government. While on one front, the Health Ministry of El Salvador approved successful pharmaceutical policies that regulated the overpricing drugs, and established a renowned SUS-like system; on the other front "(…) we had comrades and members of the congress that enjoyed private health insurance paid through public funds" (Santamaria, 2018). For Santamaria, mixed messages from the leaders caused a complete rupture between institutionalised social medicine, and its grounding in the militancy of social struggles and popular movements. "We (social medicine) alienated from the universities, we alienated from the social movements, we alienated from the working class. Therefore, who were we expecting to defend the health reforms?" Santamaria concluded. At the ALAMES International Conference, I witnessed evident discontent at the idea of advancing partial reforms of the 'right to health' when members of the audience challenged the SUS for 'not being radical enough'. Considering the content explored so far, the application of the ALAMES SUS model in El Salvador

rests closer to the interpretation of the 'right to health' as access to medicines – deviating from the political promises of democratising health, acting on the social determination process, and the radical transformation of society.

The acceptance of partial reforms by the collective health movement's political practices suggested a less than emancipatory process that prompted social medicine members at the ALAMES international conference to voice their disappointment. Santamaria suggested that, once the members gained knowledge and experience of the practical problems of government affairs, the 'right to health', as accessed to SUS, changed into a mere institutional provision of medications and services. The failure to fulfil the promises of the unified healthcare system resulted in part from the pervasiveness Latin America's left-wing political leaders held towards the pressures of financial sustainability and economic growth. As Santamaria stated: "(…) our rights are misconstrued because it is easier to achieve economic growth than to meet people's needs" (2018). Resulting from the frustration of unrealised political promises, Santamaria suggested that the people who benefited from the advancement of public health reforms during *progresismo* governments suddenly turned to vote for candidates who openly pursued the definitive privatisation of healthcare. "(…), so when we analyse the goals achieved through the SUS reforms from the viewpoint of most voters now," Santamaria concludes, "we cannot help but ask: where did we fail?"

Image 6.5 Panel discussion at the XV ALAMES International Conference. The first two individuals at the table are ALAMES El Salvador representatives and leaders of the Salvador Allende Movement in the region. The first representative, wearing a cap and a coat, is Dr. Ricardo Santamaria. La Paz, Bolivia. 2018

To be clear, the integration of ALAMES members into positions of governmental power was not an isolated incident in Latin American *progresismo*. Asa Cristina Laurell was appointed Health Secretary during the Morena government in Mexico City, and participated in the Health Ministry of the Lopez-Obrador presidential administration before major flaws and controversies emerged regarding the management of the COVID-19 pandemic. Nila Heredia was twice appointed Health Minister in Evo Morales's Plurinational State of Bolivia, and made a significant contribution to the SAFCI policy explored in the last chapter. Mario Rovere and Alicia Stolkiner collaborated with the Nestor Kirchner and Cristina Fernandez government of Argentina, contributed to the regional healthcare scheme at the Bolivian border, and now support the Alberto Fernandez left-wing administration. Mario Hernandez and Ana Lucia Casallas provided support during the local government of *progresismo* Gustavo Petro in Bogota D.C. Jaime Breilh's work was pivotal in the construction of the

interculturality in health policy during the Rafael Correa government. Jose León Uzcátegui and Oscar Feo were involved in Hugo Chavez's health sector projects.

The case of El Salvador is particularly relevant, as the FMLN *progresismo* government was the only left-wing administration that implemented a comprehensive and nationwide SUS model of healthcare (excluding Brazil, which corresponds to a different epoch in the Latin American history). The SUS reform in El Salvador was inspired by a local healthcare system that the FMLN guerrillas helped set up with the poor of Guarjila in Chalatelango, one of their military bases during the country's civil war. According to Espinosa (2018a), the conflict heightened the isolationism of the region, whose social benefits were always lost in the corruption of the oligarchic state. The Guarjila population, however, did not remain passive. Supported by the FMLN guerrillas, Guarjila established an infrastructure for the provision of healthcare services to meet basic needs. "As guerrilleros, we helped with technical details and the provision of healthcare professionals," Espinoza commented, "but the people organised the distribution of the population by colonies, the provision of services, the pooling of funds, the integration of health promoters and the role of each member" (2018a). According to Espinoza, the Guarjila experience was mainly a bottom-up strategy that effectively delivered healthcare throughout the years at war. The entirety of the local healthcare experiment, which was unified and fully public, originated and was maintained by the people. The Guarjila population, he continued, became political subjects through the life struggles of state abandonment and war, which consequently left a deep sense of community self-governance and cohesiveness. For Latin American social medicine, the centrality of grassroots initiatives, social movements, popular strikes and bottom-up approaches created the capacity to embody collective principles such as solidarity, equity and reciprocity.

For Espinosa, the Guarjila experience represented an exemplary case that proved the radical transformation of society did not emerge from the leadership of ALAMES, or the determination of a government. Instead, the emancipatory goals of Latin American social medicine materialised from communities themselves, acting on the conditions of their lives, and talking with institutions that crystallised their underlying collective principles and values. In the case of the ALAMES healthcare model, the institutions involved were linked to the national government, but the actions on living conditions of life are guided and informed by the social determination research, and connected with local collectives. In this way, the SUS model is meant to be the integration of the bottom-up

initiatives of militant movements, with the top-down institution and political processes of public administrations. The radical transformation of society by ALAMES, therefore, may be interpreted as the subsumption of political and economic affairs to the active citizenship of collectives, resulting from the integration of social movements into the political decision-making process. The democratic integration of laypeople as fundamental actors in the determination of everyday life – not merely by choosing political representatives but as direct agents of political engagement – is the idea behind 'democracy in health' by the ALAMES SUS model (Cuvi, 2018).

The tension between militant principles and political practices brought about by Santamaria highlights the shift in the ALAMES SUS model from revolutionary attempts to partial reforms. The social medicine collective in governmental posts enabled the shift by dedicating themselves to the necessary struggle against continuous austerity policies and tendencies towards the commodification of healthcare characteristics of Latin America in the past decades. The remainder of this chapter briefly maps out the changes in the SUS model found in the ALAMES literature, and the shift from emancipatory objectives to healthcare concerns alone.

b) THE TRAJECTORY OF THE RIGHT TO HEALTH IN THE ALAMES LITERATURE:

Critical aspects of the SUS model can be traced back to foundational years of ALAMES. As explained in previous sections, access to healthcare was not framed in terms of 'rights', but rather as part of the solidarity and social protection nets provided by welfarist states through public policies. The commitment to broad levels of analysis and action are a remarkable feature underlying early publications on health policies, shared by ALAMES authors when addressing population well-being. Belmartino and Bloch, for example, wrote: "(…) health policy unravels the connections between the living conditions of a community, and the relationships that its members establish at the political, economic and social level" (1984:253). Rather than exclusively discussing the delivery of services, Belmartino and Bloch focused on healthcare through the role of the state as a mediator of 'social interests.' Following publications pivotal to the early collective health movement, including *Estructura Social y Medicina* (Conti, 1972)*, Saude y Sociedad* (Donnangelo, 1976) and *Lo Social en el Proceso de Salud y Enfermedad* (Laurell, 1982), Belmartino and Bloch gathered evidence from the Argentinian political trajectory to demystify the socioeconomic and political conditions that impacted population health. The authors provided a comprehensive view of society from Perón's

populist movements in the 1940s to the military regimen of the 1980s, bringing to light the co-optation of medical practices by the liberal-economic orthodoxy. In essence, they concluded that, in order to impact population health, health policies must intervene multiple domains including economic structures, the development paradigm, the standing class structure, and the social participation of communities.

Similarly, other ALAMES publications in the early years of the association framed health policies as a commitment beyond the domain of healthcare services alone. Interestingly, the publications applied a sociohistorical analysis of a specific context to unveil a bundle of elements associated with population health. These elements included the characterisation of economic, political and social phenomena, the implications of these processed upon health and disease, the relevance of the healthcare system, and the potential actions on the socioeconomic system. Books exhibiting this pattern included *Ciencias Sociales y Salud en la America Latina: Tendencias y Perspectivas* (Duarte-Nunes, 1986), *Pensar en Salud* (Testa, 1989), *La Medicina Estatal en América Latina* (García, 2016), and *Debates en Medicina Social* (Franco et al., 1991). Additionally, the main argument of these documents does not involve the delivery of services. Instead, the authors deemed many of the healthcare problems that emerged in subsequent decades to be associated with the structural reforms of neoliberal governments.

As explained in previous sections, the neoliberal reforms of the 1990s refocused the attention of the collective health movement to *managed competition*, the CUS and market-models in healthcare. Consequently, ALAMES's concerns about health policy took up the 'social rights' discourse in order to keep the relevance of health beyond healthcare delivery alone. Howard Waitzkin, honorary member of ALAMES and distinguished *Professor Emeritus of Sociology at the University of New Mexico,* and Adjunct *Professor* of Internal Medicine at the University of Illinois, explained that neoliberalism distinctively attacked "(…) the state's role in central planning and the provision of public services" (Waitzkin and Jasso-Aguilar, 2011:65). The author argued that structural reforms in Latin America aimed at dismantling the public sector and empowering the growing privatisation of healthcare. The abandonment of healthcare as social protection provided by the welfarist state involved seizing political power by local socio-political elites – mainly through the manipulation of democratic elections (such as in the cases of Colombia, Peru, and Nicaragua in the 1990s). Once in power, neoliberal governments intentionally guided the underspending of public institutions,

leading to the deterioration of its medical infrastructure, shortage of clinical resources, worsening of working conditions, and increased difficulties in coverage. In other words, the emerging right-wing governments joined with the financial sectors to artificially fabricate a crisis in the government's welfare role. The apparent 'failure' of the state boosted the potential of the private sector to redeem the provision of social security nets for the population, prompting ALAMES to respond with the 'right to health' as access to a healthcare system.

For the ALAMES collective, the dominance of neoliberal adjustments and the advancement of the healthcare market in Latin America was based on the constructed drama of a manipulated state catastrophe, and feeble public scrutiny (Waitzkin and Modell, 1974; Merhy et al., 1998; Laurell, 2001a and b; Iriat et al., 2001). By the 1990s, Waitzkin argued elsewhere (2011), the crisis in public institutions led Latin American governments to seek international loans to implement neoliberal promissory improvements. The loans were conditional, nevertheless, and bound to the expansion of economic orthodoxy in healthcare. Ultimately, Waitzkin concluded, the aggregation of allied actors and frameworks – including the financial institutions, the intergovernmental organisations, trade agreements, and international health institutions like the WHO and PAHO – shaped the direction of healthcare reforms in Latin America towards the CUS (see also Armada et al., 2001). Citing works by Laurell (1995) and Testa (1997), Iriart and colleagues added:

"The project of sector-specific reforms, carried out with the help of international loans, served as the basis for the elaboration of legal frameworks…which facilitated the operationalisation in the healthcare of the failing Welfare State discourse…Health, therefore, ceased to have the character of a fundamental right guaranteed by the state to become a market good that individuals must acquire" (2000:97)

To be clear, the authors in the quote were referring to the neoliberal models in healthcare as sector-specific reforms. Iriart and colleagues suggested that the 'welfarist' state found in Latin America before the macroeconomic changes held legal mandates that protected healthcare services, and the provision of resources. The arrival of neoliberal reforms in Latin America, however, threatened state responsibility, promoted the commodification of healthcare, and redirected the focus towards the financial sustainability of the healthcare system. Addressing the WB report 'Investing on Health' (UE, 1993), an early document on the commodification of healthcare, Laurell commented: "(…) the WB report makes health policy compatible with the neoliberal doctrine, which locates services

predominately in the private field" (1995:9). Additionally, Moyano and Escudero (2005) argued that the report simplified the concept of health to the absence of disease, promoting focalised healthcare policies aimed at the poor, and disabling the aspirations of the WHO's 'Health for All' declaration. The denial of the state's responsibility was perceived by many social medicine members as a real novelty, given the various human rights declarations adopted throughout Latin America during the end of last century (Torres and Paredes, 2005a, b; AMGBA, 2019). Consequently, Iriart and colleagues explained, the emerging structural adjustments prompted the aggregation of the SUS model to the social medicine 'right to health' as a tool to counteract the privatisation of healthcare, and the entry of market principles in welfare policies (see also Tajer, 2004).

At the beginning of the 2000s, the advancement of neoliberalism at the expense of population well-being triggered a bundle of anti-capitalist social movements in Latin America. As Laurell explained (2017c), the government's neglect to provide healthcare services, rising inequalities, and the judicialization of health (amongst other concerns) secured the establishment of *progresismo* governments, democratically boosted by social movements (see also Telteboin, 2018). Laurell added: "(…) almost all *progresismo* governments resulted from the accelerated loss of legitimacy of the neoliberal governments of the 90s that dedicated efforts to protect private property and the production of profit" (2017c). The left-wing administrations promised active resistance to the CUS and opened up the possibility of alternative approaches to reform the sector, seemly favouring the social medicine SUS model, and its newly-formed aggregation with the 'right to health' (Gonzales, 2018d).

However, significant ambiguities towards public health reforms, and the mixed messages of *progresismo* governments revealed the unwillingness of socialist leaders to transform the orthodox model in healthcare economics. As described earlier, the political incoherencies of the new left-wing elites precluded the possibility to advance the aspirations of the revolutionary collective, leaving an unsavoury sensation of defeat. After a decade of governance, Santamaria added, 'nothing truly changed' (2018). To enumerate a few examples, the Chávez-Maduro regime was satisfied with *Barrio Adentro* alone, an SUS-like system for poor neighbourhoods that provided proper healthcare delivery and advanced intersectoral policy programmes, but never materialised at a national level (see also Uzcátegui, 2014a, b). As leaders of the Partido Trabalhista, Lula da Silva and Dilma Rousseff left the growing privatisation of healthcare unaltered in the Brazilian SUS, and fell short of

committing to a profound reformation of the health policy framework (also in Costa et al., 2015). The socialist Bolivian President Evo Morales only managed to create a unified healthcare system after 12 years in power, shortly before he was removed from office due to allegations of electoral fraud in his third re-election in 2019. The new SUS model in Bolivia, therefore, was left vulnerable to transformation by the Jeanine Añez coup regime. Meanwhile, Santamaria concluded, most of the leaders mentioned above claimed for themselves public health benefits for national or international private insurance companies.

As a consequence of the shortcomings during the *progresismo* administrations, ALAMES members who were involved in governmental affairs were drawn to focus on the access to medication and services in order to maintain the few changes achieved, simultaneously neglecting broader emancipatory goals. Laurell illustrated the case by stating: “It is not the function of the Health Ministry to build houses, generate employment, increase income, improve education, etc." (2014a). Speaking from her experience as Health Secretary of Mexico City during the Lopez-Obrador administration, Laurell made clear that the appointment to an administrative post in health implied the fulfilment of expectations for that position upheld by the majority of the population. The ‘central function’ of the government for most of the voters, Laurell added, was not the ‘action upon the social determinants of health’, but the guarantee of healthcare delivery and access to medicine.

The tension between the emancipatory goals of the SUS and the sole provision of services by the CUS, which the ALAMES members in governmental post were driven to comply to, was also shown in the progression of social medicine literature from the early 2000s onwards. *The Latin American ‘right to health’* (Torres and Paredes, 2005a) was a first notable publication in an early stage of *progresismo*. The introduction of the book clarified the interpretation of the ‘right to health’ as access to the SUS by linking its realisation with the action on 'the standing socioeconomic model’, and the incompatibility with ‘neoliberal politics’ (2005a:9).

The authors oriented the analysis by contrasting the neoliberal healthcare models of private insurance companies with the social medicine emancipatory potential of the SUS. The Argentinian healthcare system by Moyano and Escudero (p.17) is an example of this critical approach. Through the sociohistorical analysis of the previous 60 years of Argentinian health policy, the authors concluded that the ‘right to health’ in the country was progressively reduced to the medicalisation

of clinical practices, with a sharp acceleration of the phenomenon during the neoliberal reforms. Despite the Perónismo government of Nestor Kirchner, Moyano and Escudero show that the efforts to advance the SUS model fragmented throughout the nation, resulting in SUS-like systems of social medicine in pockets of cities and regions, but lacking widespread impact on the structures that organised society. The *progresismo* efforts failed to bring about a unified healthcare system, due to the maintenance of the CUS as Argentina's national approach. In this way, Moyano and Escudero concluded, social medicine efforts in the country became small collectives of resistance that competed for resources in a market dominated by principles of privatisation.

The struggle for the 'right to health' in Latin America (Gonzales et al., 2014) is a second archived work in the ALAMES repertoire. The book was published during the peak of *progresismo* in Latin America. It is notably a joint effort between ALAMES and the People's Health Movement (PHM), an international network set up by former WHO Director-General Halfdan Mahler, that brought together actors committed to defending the 'right to health'. Presumably due to the progression of the left-wing governments in the region at the time, the study goes further than previous publications by presenting "the material related to the neoliberal reforms in health and the resistance against it in places like Chile, Peru, Colombia, Mexico, and the Dominican Republic" (Heredia et al., 2014:5). It is ALAMES's most detailed work, analysing the tension between the CUS and the unified healthcare system. A group of chapters predominately revises the effects of the market healthcare on societal concerns, including the widening of health inequities and limitations of the 'right to health' on mandates for the access of essential packages of services. The publication's approach largely simplified the social determination processes to questions associated with the neoliberal model of healthcare. The case is illustrated by Uzcátegui's chapter on the *Barrio Adentro,* Venezuela's national social welfare program. As an adamant defender of the Chávez regime, Uzcátegui explained that the epistemological foundation of the *Barrio Adentro* included:

> "(…) *health not limited only to the increased acquisition of doctors, medications, equipment, and infrastructure; but also the demands of a dignified living-space, the generation of jobs, the construction of sports fields, the promotion of physical activity and education, the protection of culture and the improvement of the natural environment" (2014b:99)*

For Uzcátegui, Venezuela's Constitutional Assembly of 1998, and the rise of Hugo Chavez's *progresismo* government represented real attempts at economic, social, and political revolution, advancing the 'right to health' in the way social medicine intended by. *Barrio Adentro* represented the most ambitious attempt in the advancement of the ALAMES goals by integrating "(…) healthcare policy alongside the development of other projects including social production, education, urban improvements and nutrition" (2014b:17). Additionally, the programme sponsored the Alma-Ata declaration, emphasised healthcare as an issue of 'social rights,' and focused on the most vulnerable population of the country. In principle, the approach was meant to be a stepping stone for a radical transformation of Venezuelan society, by enabling action on the social determination processes, and the realisation of democracy in health. However, the actual success of this endeavour remains mostly unknown to the ALAMES collective.

The most recent publication that comprehensively revises the 'right to health' as access to the SUS in ALAMES is the book *Towards the Universal 'right to health': A Latin American agenda of analysis and struggle,* edited by Carolina Telteboin and Asa Cristina Laurell (2015). In contrast to previous publications, the book takes a slightly different approach to the 'right to health' by expanding on sociological debates at a more abstract level (rather than exclusively analysing the application of healthcare models in the region). This shift in approach suggests the re-commitment of the social medicine collective to the SUS model as both the provision of healthcare services, and the democratisation of health. Gonzales's chapter on the moral model of the neoliberal healthcare policies illustrates this point (p140).

Image 6.6 Front cover of the book titled "Towards the Universal 'right to health': A Latin American agenda of analysis and struggle." The book is published by UAM-X and CLACSO, both closely linked institutions to ALAMES. Contributions come from ALAMES leaders including Ana Maria Costa (former ALAMES general coordination and ALAMES Brazil representative), Mauricio Torres (ALAMES Colombia), and Leticia Artiles (ALAMES Cuba), amongst others.

Gonzales argued that liberal political philosophy grounds the neoliberal model of healthcare by rooting its practices in ethical principles like 'equality of opportunity'. Liberalism defends the state's responsibility to provide individuals with the necessary means to secure their value in terms of 'human capital' – including education, healthcare, housing, and other social benefits. However, he continued, the provision of these means is only guaranteed to the segment of the population that 'failed' in its individual duty to acquire the basic standard of living, based on the assumption that neoliberal societies provide an equal start on social conditions. That is to say, according to liberalism, state responsibility only applies to 'the poor,' the 'disowned', or the lower extreme of the social hierarchy, who carry a profound sense of public shame for their reliance on government benefits.

For Gonzales, nevertheless, "(…) the even start of societies is nothing more than the alibi to justify the existence of social inequalities, which are the product of the original injustices of neo-colonial private property" (2015:142). In the case of Latin America, Gonzales argued that the original inequalities stem from the 'accumulation by dispossession' generated by the extractive economy of ruling elites in the region (the mining industry, oil extraction and land exploitation). By obscuring the inequalities of extractivism in Latin America, Gonzales concluded, neoliberal policies are unable to address the real needs of the population. The health policies of neoliberal governments invariably remain at the level of cost containment, the commodification of services, and the expansion of limited coverage in healthcare. Consequently, he intended to redirect the academic and political gaze towards actions on the social determination processes, constructed historically by colonialism and the extractivist economy. His chapter is an outstanding effort to make the 'right to health' a critical analysis beyond medical services or access to medicine, and towards a philosophical, sociological, and historical engagement instead.

V. CONCLUSION:

This chapter revised the Latin American social medicine SUS healthcare model and its close association with debates regarding the 'right to health'. In essence, the ALAMES unified healthcare model is a strategy aimed at achieving the radical transformation of society's dual nature. On one hand, Latin American social medicine maintained the critical epistemology of previous chapters by prioritising action to the social determination processes in health. The endeavour envisioned a full commitment to the activism of social movements in their struggle for the betterment of living and working conditions. The prevalent status of bottom-up approaches implied that the collective fulfilled a supporting role in guiding the political actions and ways of reasoning from the intellectual role advanced in academia, and connected them to government institutions and top-down health programmes. On the other hand, the SUS model also involved institutional efforts to guarantee the provision of healthcare services, technology and medications – fitting the needs of the population. The ALAMES 'right to health' with access to the SUS system, therefore, advanced the values and principles that the collective health movement had embodied for decades.

The chapter opened up the discussion through a brief revision of the judicialization of health, and its relationship with the Brazilian *Sanitarista* movement. Though the Brazilian Collective Health paradigm was a distinct branch of Latin American social medicine, the *Sanitarista* movement had an historical closeness with ALAMES via its mutual collaboration with the region's social struggles. With regards to a unified healthcare system, the Brazilian collective health movement oriented ALAMES towards democratic means in order to achieve emancipatory goals through the country's sanitary reform in the late 1980s. This reform was meant to establish the SUS to achieve broader societal objectives, including the transformation of conditions in health, the radical democratisation of the system, and the strengthening of the new political subjects emerging from the sanitary movements. This chapter examined the development of the Brazilian sanitary reform exposing the 'pharmaceuticalisation of public health' and its transformation of the 'right to health' from access to SUS to the access to medications. Engagement with health litigation (that stemmed from the social struggles for the access to antiretroviral medications for patients with HIV/AIDS) revealed the process through which the Brazilian sanitary reform came to be reinterpreted as more concerned with the delivery of healthcare alone. The historical trajectory of the Brazilian SUS, in this way, showed the transformation of the social medicine healthcare model from the pursuit of emancipatory goals to the partial reform of sector-specific medical care.

Lastly, the chapter revised the specifics of the ALAMES SUS, vis-à-vis the neoliberal models of healthcare in the region in the late twentieth century, with the advent of macroeconomic reforms. According to ALAMES members, the neoliberal reforms introduced *structural pluralism* or CUS model, firmly established in the privatisation of healthcare systems, and the commodification of services. Aside from provoking the expansion of the judicialisation of health, this chapter also unveiled the impending need for Latin American social medicine to respond to the threats of the market in health. This was to be done by proposing a counter-model that integrated the 'right to health' as access to healthcare and the unified healthcare system or SUS. Similar to the *Sanitarista* movement, the ALAMES' SUS aimed at using institutional approaches to achieve broader societal goals, including action on the social determinations processes, the integration of social movement in decision-making instances, and instituting vertical policies with bottom-up initiatives. However, with the advent of the *progresismo* government in the region, once the SUS approach was put into practice, ALAMES members in government posts were required to devote their focus to guaranteeing healthcare delivery for the broader population. The change from militancy principles

to political practices forced the social medicine collective to face the realities of public administration, and to begin a very different struggle than the one intended. This fundamentally transformed the SUS from an emancipatory project to partial reform. The narrowing of the objectives, nevertheless, is a feature of ongoing tension and debate in the contemporary progress of Latin American social medicine thought style.

CHAPTER 7

CONCLUSION: TOWARDS THE INTEGRATION OF SITUATED EPISTEMOLOGIES IN HEALTH

I. THE IMPACT OF SITUATED RESEARCH TO GLOBAL PERSPECTIVES:

"Social medicine is not only juxtaposing, sequencing and coordinating knowledge, but implies transcending, transgressing and transforming health epistemology…It means a more profound complementarity, integration and collaborations. And to do that, we need to work with a clear, critical, intercultural and strategic science programme that provides contemporary struggles with all the critical science and instrumental resources needed – that is, provide a combination of knowledge. Not only academic knowledge but also the knowledge of the people."

- **Jaime Breilh, former Chancellor of Universidad Andina *Simón Bolívar* in Ecuador and former ALAMES General Coordinator. Conference titled: Towards a Public Health for Liberation. 2018b.**

Through the finely grained exploration of the Latin American social medicine Association ALAMES, this thesis offered a critical entry point to non-dominant and situated thought styles as an alternative historical epistemology for social medicine. Excavating the socio-political contours of this thought style required a departure from compiling a linear, conventional history, and instead focussed on personal accounts from which to construct the trajectory of ALAMES and the embodiment of the social world it crafted. Applying the exploration of the association's collective biography as an approach complement ethnomethodology allowed retelling context-sensitive stories and members' experiences. For ALAMES, the situated experiences of twentieth-century Latin America became the objective facts fundamental to the collective's commons-sense in ways that are unique to the collective. This thesis provided an analysis of the thought style, as well as a sense of situatedness taken from grounded perspectives. Values, political commitments, epistemological

standards, and social objectives relative to the context were explored - all elements that speak back to dominant ways of reasoning about the social basis of health and disease.

Taking Latin America's social medicine thought style as a paradigmatic case of local knowledge and situated epistemology reveals the high value of particularised ways of conceiving the relationship between health and society. The collective health movement illuminated the path on ways of thinking about health from subaltern perspectives that openly resist the universalising health epistemologies like biomedicine. As explored in the thesis, to ALAMES, the hegemonic medical model is considered a capitalist, exclusivist, monocultural, technical, managerial, and skewed perspective that prioritises individualised healthcare services at the expense of broader societal concerns. By contrast, the association's thought style claims to provide key heuristic resources to understand the social dimensions of knowledge construction in health, to interpret the immediate realities of Latin America, and to make sense of experiences lived on the ground. By doing so, the collective health movement seeks to uncover systemic oppression, structural injustices, and power asymmetries within the societies, empowering the struggle of social movements against the structures.

ALAMES offered a wealth of concepts, frameworks and arguments that elaborated a positioned and structured perspective of Latin America, population health, and its relationship with underlying social processes. The perspective is an alternative way for groups to know themselves, others and the reality of the world around them. Studying the situated epistemology of ALAMES contributes in the understanding of how the context of power relations and its experiences are transformed into fundamental units of reasoning that shape the thought style and its persona. Most importantly, ALAMES attempts to bring together multiple local knowledge from 'the south,' with the understanding that each standpoint remains partial, imperfect and ever-changing. Yet, the task of incorporating different particularised views is necessary for the contemporary aspiration of knowledge in health. Social medicine in Latin America, therefore, seeks to take seriously the multiplicity of local experiences and the struggles on the ground; providing a valuable contribution to global health scholarship researching Latin America. The ultimate goal of ALAMES is to support a dialogue that does not seek a unified theory of health, nor disregard the context for being problematic, but engages all standpoints that enable what Silva Paim referred as "(…) the

advancement of health science to enhance the development of population health and happiness" (2017, see introduction).

ALAMES also provided different claims on how we ought to improve political practices in light of the social struggles and claims made by movements, protests and grassroots initiatives. Multiple demands for the elimination of injustices by marginalised groups in Latin America joined social medicine efforts to transform contemporary health epistemology into a form of thinking that remains sensitive and responsive to the actual needs emerging from the context. For Latin American social medicine, health epistemology must reject the omniscient, disembodied, and unmarked perspective of biomedical exclusivism. According to ALAMES scholars, this type of exclusivism imposes a reductionist perspective that rejects situated experiences to achieve an unduly sense of objectivity, neutrality, impartiality, and homogenisation of truth-claims – simultaneously reproducing the marginalisation of vulnerable groups. To tackle exclusivism, social medicine distinguishes itself for its claimed capacity to differentiate between knowledge that integrates the situated experiences of the subjugated, and knowledge that neutralises local processes. Consequently, this thesis uncovered the concerns, commitments and objectives of ALAMES to speak against the dominance of capitalism, the co-optation of biomedicine, the epistemic injustice of modernity, the colonial heritage in epistemology, the commodification of healthcare, and the conceptualisation of reality in biological terms alone.

The concluding chapter brings the main features of Latin American social medicine thought style together to consider its contributions to global health and broader social medicine research. A comprehensive exploration of the primary debates proposed in this thesis evaluates how the situated epistemology of ALAMES faces contemporary challenges, including the uncertainties of the post-COVID world ahead. The analysis questions the tendency of dominant epistemologies to disregard local knowledge and situated epistemologies in the understanding of health and disease, silencing embodied worldviews and subaltern civilising projects. According to ALAMES, by doing so, health sciences like biomedicine fail to consider that knowledge production is a social process where multiple standpoints and perspectives aggregate in a dynamic that reconstructs reality for pragmatic, procedural and moral goals. Ultimately, the chapter is a defence of the role and importance of locally-situated values, concerns and commitments to the development of knowledge

and the production of evidence. This highlights the conceptual and moral richness emerging from thought styles that thrive in conditions of oppression.

Readers will notice the closeness of the concluding remarks with the work developed by feministic scholars on 'situated epistemologies' (Haraway, 1988; Nightingale, 2003; Lang, 2011; McCann and Kim, 2013; Yadav, 2018; Grasswick, 2018; Anderson, 2019; Longino, 2020). Whereas feminist scholars use the concept of 'gender' to understand how power asymmetries come to play a fundamental role in the constitution of knowledge, this chapter suggests the operationalisation of 'context' as an alternative category that enables a similar analysis of the social realities in the field of population health research. The difference lies on the particularities of health as a field of research, which the critical analysis of Latin American social medicine in this thesis helps to clarify. Consequently, some of the key elements this study of the situated thought style of ALAMES has unveiled looks ahead to what lies in the future of this thought style.

The chapter is organised into three segments. The first two segments consider a recurrent idea found throughout the empirical data, and which remains relevant for Latin American social medicine to this day: the concerns against exclusivism – or the exclusion of persons, groups or epistemes from a valuable social status. The first segment explores exclusivism in light of the underlying social, political, economic and cultural ethos of contemporary Latin American societies for ALAMES - namely capitalism. The conceptualisation of this term, and the way operationalised by the collective health movement, reveals a substantive element of the thought style in each of the chapters revised. Capitalism has acted as a driving force for the collective health movement, moving it from a socioeconomic model, to a way of understanding health and disease, to a 'civilising project', and finally a healthcare system model. Additionally, the chapter examines exclusivism in light of the 'epistemic injustice', which the dominant epistemology in health has held over ALAMES's history. Mostly explored in chapter four, 'epistemic injustice' is the exclusion of a thought style on the basis of historically constructed criteria. The injustice can be seen throughout the thesis as a fundamental process that has motivated the social medicine critical engagement. Injustices against ways of thinking are found in the struggle of critical social theory in health during the foundational years of the collective, the dominance of the *Hegemonic Medical Model,* the tendency to render invisible *El Buen Vivir* and Indigenous communities, among others. A brief reflection of these finding on the

current COVID-19 crisis, grounding what may become of the ALAMES view in a post-COVID world, forms the conclusion and last segment.

II. ALAMES AS A NON-DOMINANT AND SITUATED EPISTEMOLOGY:

The work of Latin American social medicine shows a concern for the relationship between hegemonic and non-hegemonic ways of reasoning health and disease since the second half of the twentieth-century. As explained above, the underlying focus of this concern is the idea of 'exclusivism' and the ways in which this type of relationship has articulated and elaborated the ALAMES thought style to operationalize the collective rational and practices. Exclusivism, therefore, figures as a recurring notion cutting across the doctoral research to help answer the questions posed in the introductory remarks of the thesis, mainly, how do we begin to think about situated and non-dominant ways of thinking health and disease? A first approach to 'exclusivism' helps bring together the main features of ALAMES thought style, which is built into the social medicine conceptualisation of 'capitalism' - a guiding category that shapes the changing features of the movement's *persona*.

ALAMES is known for constructing a radical critique of capitalism in the second half of twentieth-century Latin America. In the collective's biography, explored in chapter three, social medicine conceptualized capitalism as the root cause of the social processes that determined population health locally. The collective health movement emerged with a critical stance against the progression of the developmental policies of the 1960s, where governments across the region implemented and institutionalised public health, imported from the US via philanthrocapitalism. The narrative against post-Second World War capitalism zoomed in on the 'sanitary reality' according to social medicine, distinctive for revealing the abandonment of local socioeconomic structures to the power asymmetries of the extractivist economy. ALAMES members argued that extractivism made 'peripheral' Latin American societies dependent on the 'central' determination of Euro-American affairs. Some consequences of this regional dependency echoed the process of industrialism of nineteenth-century Europe, such as the growing inequities between urban and rural areas, the increasing pauperism or rings of misery in cities, and the need for basic sanitary services as a matter of population health. Other consequences were particular to the local context, including

growing partnerships between the political elite and feudal landlords to secure financial advantages in the creation of oligarchic states, and the exploitation of cheap labour and resources to favour the profits of transnational corporations that mingled in local political affairs.

According to ALAMES, the historical trajectory of the emerging global market of the 1960s and 1970s, structurally conditioned the poor sanitation and limited healthcare resources that threatened the well-being of Latin American populations. The growing masses rose up against the living and working conditions, which justified the emergence of a Latin American social medicine network to counteract the pervasiveness of the capitalist socioeconomic model. This militancy originated from the 1970s context of state violence, authoritarian persecution, political repression, and even death threats to a growing mass of intellectual and political leaders who opposed the right-wing dictatorships. The phenomenon was captured by social medicine pioneer Juan Cesar García, who was working at the PAHO Department of Human Resources at the time. As described in the thesis, Garcia used diverse health research programmes to bring together a myriad of academics who shared the underlying struggle, and relied on critical theory to provide voice and agency to the sufferings and uncertainties. On the establishment of the Latin American social medicine network, various members sought the solidarity, camaraderie and empathy of other scholars across the region to flee their home countries and to find refuge from persecution. As a result, ALAMES crafted values, principles, and commitments that reflected revolutionary, emancipatory and subversive objectives associated with the radical transformation of Latin American liberal, capitalist and western-centric societies. The ultimate expression of efforts began at the 'Cuenca I' meeting in 1972, and culminated in the conformation of ALAMES in 1984 at Ouro Preto, Brazil.

In this way, the ALAMES narrative against capitalism performed both as a critical framework to tackle the 'sanitary reality', as well as the language to sustain the emancipatory potential of the social medicine thought style. The crafting of values resulted in the social medicine ethos, also known as the *militante*, which was manifested in two ways. On one hand, the belligerent *guerrillero* was explored through the profiles of Eduardo Espinosa and Nila Heredia, members who were closely linked with the National Liberation Armies across the region. The movement sought to transform political power through armed conflict, and by the end of the twentieth-century, eventually shifted to political parties and democratic collectives. The shift was due to factors such as the demise of the Soviet bloc, and the delegitimisation of violent means. On the other hand, militancy was also found

in academia in the figures of *organic intellectual* leaders like Saul Franco, Jaime Breilh, and Alicia Stolkiner. The academic militancy captured the claims and vindications of the social movements, and mixed them with the rising centrality of critical theory at public universities. In this way, the collective histories, narratives and arguments brought about by the thought style did not merely reflect the intent of social medicine to become a supplementary approach to the institutionalised public health. Rather, the collective biography of ALAMES unveiled a thought style focused on impacting what they perceived to be the capitalist-derived power asymmetries, structural injustices, and systematic oppression that social movements and popular protests flagged. The non-dominant position of ALAMES identified how hegemonic epistemologies in the region lacked the tools and resource to provide local struggles with a voice.

The way 'situatedness' is perceived in the thought style, therefore, reflects more the believe that the claims and struggles of social groups across Latin America have a common root cause in twentieth-century capitalism – rather than the conceptualization of 'situatedness' as the particularities or specificities of each narrative of oppression and injustice which the groups themselves experienced. Latin American social medicine then integrates all these struggles, as though one, explaining all struggles based on the Marxist theoretical framework and critical analysis. In itself, covering struggles under the umbrella of Marxism does not do justice to the claims and vindication sought for by the groups struggling on the ground. It does, nevertheless, reflect a consistent practice envisioned by the collective: the disregard for the particularities of the social movements by relying on historical materialism as a wolrdview. Whether Marxist theory is accurate in depicting the reality of local groups extends beyond the limits of the present research. The point intended is to highlight the limits and tensions which the claim for situatedness that ALAMES makes has on the general contribution to critical global health made by Latin American social medicine.

The link between the socio-political turmoil of the time, the ALAMES militant ethos, and critical social science introduced into the study of health and disease converged with the situated experiences of the collective. As expanded in chapter three and four, though social medicine academics recognised the presence of social theory in the institutionalised public health, members argued that these views were merely functional for the purposes of expanding capitalism. The more critical social sciences, brought about by applying historical materialism to health, was the type of scholarly work deemed necessary by social medicine for a militant doctor who wanted to make an

impact on the world of dictatorship, violence, and exploitation. The centrality of Marx's critical theory in ALAMES lay in the 'anti-American' and anti-capitalist spirit of the time. By exploring the personal trajectories of scholars in the situated thought style, distinctive insights revealed how the local socioeconomic, political, and cultural milieu were embodied as objective facts for the crafting of the ALAMES thought style. The militant persona was not a random construction in an attempt to imprint their own metanarrative into the collective's ethos, nor a persona to fit the rising Marxist discourse emerging at public universities during the '60s and 70s'. Rather, the integration of a critical social science in the form of historical materialism was a response to the grounded perception that socialism was the only possible way to move forward *vis-à-vis* the wave of right-wing dictatorships and oligarchic states – that is, a way to embody the reality of the context.

Alongside a socioeconomic model, ALAMES conceived 'capitalism' in the second half of the twentieth-century as a way to interpret the relationship between health and society. Chapter four specifically elaborated on the *Desarrollismo* of public health, or how capitalism captured health epistemology to determine an essentialist view over health and disease. Also termed *preventivismo*, ALAMES members such as Asa Cristina Laurell and Jaime Breilh argued that the dominant medical practices redefined health in 'linear' terms, connecting variables impacting health like a cascade of events eventually resulting in population health outcomes. For these authors, perceiving reality merely as a series of 'risk factors' severely limited the capacity of research to consider and study underlying social processes that rendered these factors possible in the first place. The *preventivismo* model failed to account for the power asymmetries, structural injustices, and systematic oppression that made up the process of health and disease in Latin American societies. Capitalism in health obscured the causes that explained standing health inequities and its associated phenomena. Consequently, the fragmented view of institutionalised public health limited its impact to action on particular health parameters, like the morbidity and mortality of certain vulnerable sectors of society, while leaving intact the very processes that created the inequities in western societies. For many ALAMES members, this limited risk factor perspective also permeates much of the literature in the Social Determinants of Health so prominent today.

The dominance of the capitalist *preventivismo*, moreover, made evident the relationship between the hegemonic and non-hegemonic ways of thinking health and disease. The ALAMES *counterhegemony* presented a situated perspective focused on re-invigorating the critical stance

against the underlying social processes that determine health, and were obscured or made invisible by the biomedical *hegemony*. In so doing, social medicine operationalised concepts such as 'subsumption', the singular-partial-general social hierarchies, and the social reproduction/production using the social determination model for the purposes of capturing the social basis of health and disease. As a result of exploring the ALAMES perspective, categories like the context, social location, epistemological position and situated standpoints acquired a significant heuristic value as resources for social movements and popular struggles to expand an understanding of ongoing power relations. In crafting a situated epistemology that not only differed but also resisted dominant accounts found in biomedicine and institutionalised public health, the collective made it clear that health research may have the same object of study, but must integrate different perspectives that are locally and contextually informed.

By embodying the particular context of the Latin American asymmetries and injustices, ALAMES provided a vantage point that unearthed the rationale and practices of one specific bundle of subaltern groups. The social determination model showed how the association sought to represent the claims and requirements of the less powerful in attempts to depict their realities accurately, as well as to provide the epistemic resources to grant meaning to their experiences, and construct tools to help them in their emancipatory goals. The risk, nevertheless, is to assume that ALAMES truly inhabits the social struggles of all collectives ascribed to it (social movements and popular protests) - when it mainly represents the experiences of members that suffered the context of twentieth-century dictatorships and violence. The gap between member's experiences and other collective struggles is still evident and unresolved. ALAMES does not conceive the reality of marginalised groups from a first-person perspective, but rather from the borrowed perspective of subjugated collectives that have come to join its ranks. The position of ALAMES, therefore, is not exempt from scrutiny, re-examination or analysis by Latin American social movements themselves.

Put differently, not only is ALAMES utilising Marxism to bundle all experiences from Latin American oppressed groups, but it is also representing a specific standpoint which more accurately captures the lived experiences of the leaders and representatives (but does not necessarily makes justice to the particular claims and vindications of the different groups involved with ALAMES). In this way, for instance, one ought to question the extent to which these groups and other individuals actually have voice and vote in the association. Provided that the research node on social movement,

presumably the most direct move ALAMES has made to get direct involvement from social movements, only occurred until 2018; it is possible that the direct involvement of social groups remains a marginal issue within ALAMES.

Moreover, in light of the tension above, ALAMES' attempt to present the collective as a 'unified body' or a homogenous collective is also challenged by the multiple disagreements and contestations that the thesis explored. Chapter five delved into the re-shaping of the thought style through the clash with indigenous movements. The latter, as explored in the chapter, collided with ALAMES in both the fundamental history determining the collective ethos and the political subject central to the region's social transformation. As a result of the clash, social medicine re-framed 'capitalism' not merely as the economic structures of society or the causal explanations in health epistemology, but also as the foundational perspective of daily living or the common-sense of the broader Latin American population. Hence, the concept of 'capitalism' morphed into a far more complex phenomenon that encompassed a foundational way of thinking. This foundational thinking reproduced the social system of asymmetries, oppression and injustices based on racism, elitism, and genderism in Latin America. The ALAMES interculturality laid bare the struggles against the universalising view of western exclusivism on which capitalism has been based since colonial times, and structurally determined the ethos of contemporary societies in Latin America.

The exclusivism of capitalism is best described as the 'crisis of civilisation' (Feo, 2014; Valencia, 2014; Uzcategui, 2014a; Breilh, 2020b; ALAMES, 2020a, e, f). The 'crisis' refers to the multiple problems emerging in different spheres of contemporary western societies, including the acceleration of climate change, the exhaustion of natural resources by regional dependency on the extractivist economy, the recurrent financial crashes on stock markets, growing international debt of local governments, the reinforcement of austerity measures at the expense of social security nets, the rampant increase of social disparities, the growing gap of the income inequality within and between countries, and the return of precariousness in living and working conditions, among others. The ALAMES members argue that the crisis is one of 'civilisation' as the complexity of the problem cannot be framed merely in terms of capitalism vs. socialism (or socioeconomic models).

According to ALAMES scholars, the advent of the *progresismo* governments in Latin America represented a beacon of hope for socialist partisans who looked up to these figures as a definite

transformation of regional politics. Presumably, the change in the political perspective would enable definite ways out of the crisis. However, the reality of Latin American socialism yielded a very different horizon from the one anticipated. ALAMES members criticised *progresismo* administrations for replicating the same disparities, asymmetries and oppressions that underlay the region's plight. With the integration of Indigenous movements and the interculturality debate, the social medicine collective began conceiving the predicament not merely as an issue of capitalism as a socioeconomic model, but as a 'civilising project' that grounded both capitalism and socialism in our time. The fact that *progresismo* did not alter the fundamental disparities in the region proved, for many ALAMES representatives, that the problem rests at the foundational epistemology that acted as the driving force of contemporary western societies – rather than the type of politics being defended (capitalism vs socialism).

The ALAMES conceptualization of 'capitalism' developed further in the 1990s with the neoliberal wave of structural reforms in the region. In particular, the exclusivist ethos of the capitalist project focused on the healthcare system through the advent of the CUS healthcare model, forcing an emphasis on the social medicine collective to resist privatisation, and the commodification of healthcare services. The model social medicine proposed in response, otherwise known as the Unified Healthcare System or SUS, consisted on two fundamental features. On one side, the provision of services and resources through a system that is publically-funded, universal in coverage, free at point of entry, and centralized through state institutions. On the other side, the SUS sponsored a type of 'democratisation' the involved the inclusion of marginalised groups into the decision-making process in health. Due to multiple factors, including the demise of state centrality, the overwhelming rhetoric of financial growth, the historical collapse of the soviet bloc, the delegitimisation of socialist ideology, amongst others; the collective incorporated the 'right to health' discourse into arguments for the SUS healthcare as the only possible and effective way to maintain resistance. The integration of 'rights' language into ALAMES's concerns for state responsibilities and healthcare system (as explored in chapter six), therefore, did not simply result from a spark of creativity in the collective consciousness of the movement. Despite the fact that many members of the collective opposed the 'rights' discourse for its proximity with liberal political philosophy, ALAMES adopted the language and modified it to move away from individual entitlement to access drugs via court mandates.

The situatedness of ALAMES also reveals two fundamental features about local knowledge, which the thesis explored through the collective's narrative.

Firstly, the social medicine situated epistemology highlighted the importance of 'embodiment,' pointing out that thought collectives materially experience the immediate context through the interaction of their bodies with the social processes around them (Breilh, 2013). The first-person perspective of the circumstances at hand produced a type of knowledge about systematic oppression, structural injustices and standing domination that remains unique, privileged and incommensurable in relation to third-person accounts of the same phenomenon commonly found in academia. To study the situated thought style of social medicine, therefore, is to fully understand the ways a context inhabits a situated body.

Secondly, ALAMES as a situated epistemology also portrays the beliefs and worldviews that abound in the context. Various subjugated groups that constituted the ALAMES collective emerged from particular views about the world that guided different interpretations of medical practices, causes and progression of disease, and the role or scope of health epistemologies. The integration of distinctive worldview by ALAMES yielded methodological and epistemic challenges that were not necessarily a topic of concern in the foundational years of the social medicine thought style. Such is the case in the debate between social medicine and the *Buen Vivir* worldview that redefined the political subject in Latin America as the *pueblo originario.* This situated the historical background of the region as emerging from colonialism and coloniality, and re-interpreted medical knowledge and practices as stemming from spirituality and traditional medicine. ALAMES view of social medicine accessed context-sensitive knowledge by providing a platform to voices such as Amauta Gueran, David Choquehuanca and Antonio Valencia, resulting in an epistemological engagement that is otherwise difficult to realise from external standpoints not grounded in the same norms, social spaces, interests, etc. The study of situated thought styles, therefore, helps to access these local perspectives by rendering the social position of collectives explicable, transforming situated experiences into a common ground of epistemological analysis. As researchers cannot relocate to the vantage point of the subjugated, nor experience the situated spaces of being afflicted; Latin American social medicine provided a point of entry into the reality of Latin America's health epistemologies by translating the embodied context into epistemological language.

Ultimately, this thesis ties the context of struggle and oppression of twentieth-century Latin America closely to the epistemic position and ideological outlook of social medicine collective. It explores the subjugated position of ALAMES and its potential to be a more reliable viewpoint in the knowledge-production emerging from Latin America. By being situated, the Latin American social medicine thought style represents a standpoint from which the reality of struggles, oppression and persecution in health characteristic of the region can be better distinguished and recognised. The underlying motivation of resistance and opposition strengthens the collective's belief to become an antagonistic, revolutionary and subversive intellectual movement that is well-placed to generate knowledge and practices from the perspective of the oppressed.

Latin American social medicine presents itself as a thought collective embedded in the asymmetries and exclusivism of capitalism, offering a unique position from which the dynamics of local injustice can be most appropriately understood. In the biographies explored, ALAMES members argued that the biomedical perspective was interested in maintaining epistemic authority, geared by the exponential growth of the global market co-opting health research. The situated epistemology of ALAMES, as the socially disadvantaged thought style, can achieve a richer understanding of the oppressive social relations with capitalist biomedicine to capture the true nature of this relationship, and propose ways of emancipation.

III. A SITUATED THOUGHT STYLE TRANSFORMING HEALTH EPISTEMOLOGY:

Latin American social medicine informs the perspectival nature of knowledge, and contributes to the effort of analysing truth-claims from the subjugated viewpoints of the Global South. That is to say, 'Global South' not as the term used to disdainfully describe perspectives that are 'underdeveloped' or developing towards the illusory benchmarks proposed by the 'Global North.' Rather, 'Global South' as the term to capture the marginalised or neglected groups that represent contexts which remain prey to coloniality, imperialism and racism at the political, socioeconomic and epistemological level. As described elsewhere in this thesis, Latin American social medicine pays close attention to the intersection of power asymmetries that determines population, in what is known as the 'triple inequalities' (Breilh, 2003a:36). These inequities refer to the exclusiveness

emerging from class oppression (capitalism), gender domination (patriarchy), and ethnic injustices (neo-colonialism).

A second way in which the notion of 'exclusivism' helps to bring together the main features of social medicine includes the struggle against 'epistemic injustice' in the context of contemporary liberal, biomedical and western societies. As elaborated in chapter four, epistemic injustice refers to a type of status asymmetry among epistemes or thought styles based on arbitrary criteria constructed throughout the trajectory of societies. These criteria determine the validity of the style of reasoning in absolute terms, rendering some perspectives adequate, accurate and/or superior; other perspectives inadequate, inaccurate and/or inferior – and yet others invisible, unworthy and irrelevant. The ALAMES narrative showed the progression of epistemic injustice in Latin America over time. The first moment is found in the ALAMES narrative of the so-called *Hegemonic Medical Model,* the health epistemology imposed on Latin America through the medical curriculum reform of Preventive Medicine in the 1960s and 1970s. The social medicine narrative of *preventivismo* revealed the marginalization of the critical social sciences applied to health, a perspective which was pivotal to Latin American social medicine network during this time. The injustice perpetuated to the critical social sciences, based on the predisposition against socialist and communist ideologies typical of capitalist policies in the region, reinforced the constructed superiority of the biomedical paradigm over social medicine. The predominance of North American structural functionalism and positivist approaches found in preventive medicine, and applied to make sense of population health, configured a benchmark that judged the situated ALAMES thought style as unfit for the expectations of what a thought style in health should look like.

As various ALAMES representatives have explained, universalising epistemologies such as biomedicine, assumed that 'the context' was irrelevant and even detrimental for knowledge-construction and truth-claims. Therefore, the approach applied a form of methodological solipsism to maintain its epistemological exclusiveness, becoming antithetical to the social basis of health and disease as portrayed by the Social Determination model. Naturally, knowledge-making in health disproportionately focused on the evidence that reinforces the dominant approach of biomedicine, rendering different types of evidence less worthy and/or invisible. The fundamental objective in the epistemological basis of Latin American social medicine is the recognition that health and disease are historically determined, reigniting the need to consider the intrinsically complex nature of 'the

context' that makes possible the distribution of population health and disease. The social basis of health and disease, understood by the collective health movement as the processes underlying risk factors, made the ALAMES situated epistemology favour contextual analysis, making knowledge-production and evidence-claims a field of dispute for the social medicine collective.

As explored in chapter four, Latin American social medicine claimed to think and act on behalf of the oppressed and underprivileged that endorsed the thought style. In so doing, it self-ascribed an advantaged perspective over politically-contested topics associated with subordination, domination, and injustice. Social medicine opposed the misrepresentation of biomedical and western exclusivism as inevitable, essential, and universally advantageous; rejecting the tendency of biomedicine to depoliticise medical practices and health. The ALAMES epistemological contributions produced a collective consciousness of the standing oppression and injustices of the Latin American social system. By conceptualising the levels of determination as a dialectical relationship, Latin American social medicine made evident that the structural determination of individual lifestyles and group modes of living reproduced oppression and injustices at every level. These inequities trickle down to the immediate reality not merely as social conditions like the quality of housing, sanitary services, access to education, food sovereignty, right occupation, adequate income, environmental care, and healthcare access; but also as the 'natural attitude', common-sense and ways of being that drive attitudes, behaviour, representations and interpretations of reality.

The Social Determination model, therefore, brought to light both the material and symbolic bases of capitalist societies, prompting the urgency to focus efforts on the radical transformation of the Latin American market-driven societies to transform epistemic injustices. With regard to the oppression, marginalisation and violence, ALAMES took a standpoint that provided epistemic resources to better understand the interests and objectives capitalism serves, makes sense of the experiences of struggle, and gained the epistemic capacity to express the suffering of social movements and protests. Latin American social medicine framework in health was used to give oppressed groups in health a voice and self-representation so they could achieve their emancipatory political goals through the language of subsumption, social reproduction, and levels of determination.

The second moment of epistemic injustice emerged from the *Buen Vivir* narrative that in the 1990s challenged the asymmetries between modern scientific reasoning and the Indigenous worldview in Latin America. ALAMES argued that dominant health epistemologies like biomedicine assert to capture the true nature of an object under study by sharply separating the knower from the known to provide an unbiased 'view from nowhere'. The self-ascribed 'neutrality' of the dominant research stemmed from its apparent independence from the context, social values, political inclinations, and cultural beliefs, giving a sense of autonomy that prided itself in being directed by data alone. For ALAMES, biomedicine ignores the fact that knowers are always constituted, situated and positioned in a given context. Likewise, the capitalist approach neglects the ways embodied standpoints permeate the choices made on what matters in knowledge construction, how to represent the objects of study, and how to present the truth-claims. By decontextualising research in this way 'universal sciences' like biomedicine appear disembodied, unmarked, and lacking presupposition or biases - bringing about evidence that remained indifferent to the real struggles of the population. The interculturality dialogue between ALAMES and the *Buen Vivir,* makes evident how the maintenance of the 'view from nowhere' above is a fundamental contributing factor to the perpetuity of injustices towards local knowledge (like those of indigeneity).

In many ways, the claims of objectivity from the universal sciences are adopted by those in power, and maintained by depoliticising their rationale and practice to the point of making certain social irregularities, injustices and dominance necessary for their own benefit. The dominance of exclusionary epistemologies dismisses the possibility of cooperation among thought styles, and strips agency away from local Indigenous collectives to govern themselves, realise their goals, and carry on their traditions. The exclusivist sciences justify their views on stereotypical biases that render indigeneity as erroneous and inferior, depriving *pueblos originarios* from epistemic authority. The structural reforms of neoliberalism, as the next historical step of the capitalism project in the 1990s, reinforced the tendency to universalise disembodied knowledge, generalise vertical practices in health, and make local knowledge less worthy. Consequently, western exclusivism denigrated *Buen Vivir* further, precluding the participation of Indigenous communities in democracy, and deepening the social gaps and marginalisation. As explored in chapter five, the collective health movement also recognised the pervasiveness of exclusivism in their own ethos by failing to incorporate indigeneity until far advanced into the neoliberal reforms. The *pueblos*

originarios became central figures of protest and mobilization during the late twentieth-century, through their resistance against extractivism, and the systematic destruction of nature.

Consequently, Latin American social medicine argued against the contemporary hierarchy of knowledge-practices and epistemologies as established by the underlying 'natural' order imposed by biomedicine. Knowledge in health for ALAMES is constituted through the aggregation of multiple perspectives on the same object of study, as recognised by the interculturality in health debate that led to the assimilation of the Indigenous worldviews in the social medicine agenda. For ALAMES, the inherent plurality of knowledge being constructed also enables the use of these perspectives according to pragmatic criteria including, for example, the pertinence of specific evidence-claims to the objectives of a particular setting. In other words, ALAMES considers appropriate to give predominance to biomedical practices in the context of hospital settings or critical-care units, understanding that, outside these spheres, other knowledge from the social sciences or traditional medicine may be more relevant. The ALAMES thought style recognises the need for an open dialogue among thought style to create a comprehensive health epistemology. This is reflected in, for instance, Saul Franco's concern for the integration of 'various disciplines and ways of reasoning;' or Ana Lucia Casallas' critique of the *cultural relativism of indigeneity,* to support the efforts of 'co-existence' among thought styles in health. The acquisition of concepts like 'meta-narrative' or 'ecologies of knowledge' reflected the association's renewed inclination to ground social medicine thought style in the epistemic pluralism of the Latin American context, and to re-imagine local history through the lenses of modernity and colonial history.

Additionally, the view from 'nowhere' also fails to consider that scientific inquiry and evidence-making is defined by social and political engagement. The biases and interests that certain groups represent aggregate as background assumptions, ubiquitous in both the researcher and the context upon which research is being made. The background assumptions that the researcher embodies makes clear that all evidence-claims are value-laden, and subjected to the processes and conditions upon which the knower is embedded. Latin American social medicine suggests no sharp division between facts and values in the production of knowledge, pointing at thought styles as reflective of particular epochs and social circumstance. Contextual values emerging from the structural injustices embodied by the collective informs their empirical inquiries and epistemological frameworks, making ALAMES the anti-capitalist, anti-imperialist and postcolonial ethos that it is.

This position echoed the so-called 'under-determination theory' in which theory based on evidence inevitably leads to the realisation that facts and values are mutually constitutive of knowledge and truth (Antony, 1993; Nelson, 1993; Anderson, 2019). Any empirical development is always dependent on norms and principles that are formed in light of a particular history and social dynamics of a context.

By contrasting dominant health epistemologies, ALAMES considers social movements to be a fundamental part of the process of knowledge production, because the struggles collectives embody also flag the most pressing concerns of ongoing structural injustices and health inequalities. Social movements rightly challenge the illusory impartiality in research by guiding scientists towards attaching their autonomy to the claims and vindications that matter at the local level. The ALAMES thought style, therefore, argued that the self-declared 'neutrality' of certain sciences in health contributes, reinforces and reproduces the western exceptionalism and epistemic injustices that movements, protests and manifestations of the 'Global South' expose through their political militancy. To assert and integrate generalising, vertical and one-size-fits-all measures without a critical reflection that uncovers the biases and evaluates the usefulness of its knowledge has been instrumental for the perpetuity of oppressive dominance and unjust structuring typical of the capitalist model of health epistemology.

Knowledge in health consists precisely on the engagement of different thought styles with communities producing local and empirical successful content, while maintaining clear accountability over claims and statements. Consequently, all health epistemologies must make explicit their situatedness, social position and epistemic location to best understand how their respective contexts have shaped their thought styles. By exploring Latin American social medicine, this thesis provided an example of how this is possible. As elaborated by Longino (2001, 2020), producing knowledge is a 'social enterprise,' stemming from the interdependent and cooperative interaction of situated standpoints that respond to evidence-claims and truth-statements. As the world faces the COVID pandemic and looks forward to the post-COVID world, the last section will position and expand on the ALAMES situated response to the global health crisis.

IV. LOOKING AT COVID AND THE POST-COVID WORLD:

Image 7.1. Interview to local citizens in a deprived neighbourhood of Bogota D.C. Adapted from 'Afuera' by PACIFISTA (2020). The caption translated from Spanish reads: "I do not have COP400.000 (roughly GBP90) to pay the rent."

A middle-aged woman, who chose to remain anonymous for the interview, appeared in a video posted on social media by an independent local journalist group, seeking to make public the voices behind the numbers in the pandemic. Her voice begins to crack, though, as she tries to explain the current situation of a sector labelled the 'invisibles' or the 'outsiders' (PACIFISTA, 2020; LSE, 2020). Behind her facemask, her pain is evident through the wrinkles on her face and the tears that she cannot contain. She pulls down the mask, against all indications from authorities on TV, trying to get a grip on her breath. "I have been working for the public service for decades," she commented, "I have saved many lives - it is not fair that now I have to beg the state for help." The images of the precarious conditions are dire: dogs are barking in the background where a marginalised area of Bogota D.C. is made visible by broken tiles of an old sidewalk, the small public space prone to overcrowding, and naked structures of low-cost housing projects.

The video begins with a man who appears to be a street sweeper. No-one is allowed to leave their homes at this point of the quarantine, but he is out 'risking it' because there is no other choice. He has been left jobless and isolated, yet still needs to provide for his family. He stated: "(…) if I had the means to share with my family every day, I'd be at peace. I wouldn't worry. But right now, I have no way to share even an ounce of food, so what can I do?" In the next frame, a Venezuelan immigrant that couldn't return to his home country compared the situation to the context he intended to escape from in the first place. He lives the same conditions in both cases: long queues from early dawn with the hope of catching the charitable donations from public officials, only to find out these aren't available for him. He gambles now, with cards and dices on the streets, before having to go and steal something to trade for food after. A profound sense of frustration is evident in his voice, as he commented that his community is now 'eating nails.'

The growing scale of the COVID19 pandemic called for the systematic application of vertical approaches, one-size-fits-all lockdown policies, predominately focused on physical isolation, the market rush to acquire ICU technology, the strengthening of healthcare preparedness, and the establishment of epidemiological systems. A wealth of public health experts across the globe brought about various mathematical models, seeking to explain the importance of 'flattening the curve' by applying the measures quickly. Within days, governments across Latin America closed their national borders, executed extraordinary legislative rights, and forced people to stay indoors at the risk of fines and public shaming if the measures were broken. We were all told the goal was to build the necessary infrastructure to face the pandemic. Meanwhile the world awaited the redeeming work of contemporary science with the help of public funds – as though vaccination and medical treatment were the only possible reactions to the disease. Nevertheless, daily newsfeeds in Latin America told of undue use of the funds, justified by the smokescreen that became the depoliticisation of the COVID response (La Pulla, 2020). Money was diverted to buy new security systems for members of Congress, supermarkets were overpricing essential products to make extra profits at the expense of need, donations were re-channelled to private pockets, and multiple allegations were on the abuse of police power against people breaking lockdown rules.

Within the first week of quarantine, countries like Colombia, Peru and Argentina announced various economic aid for their populations, in an attempt to manage the inevitable crumbling of the national economies and the knock-on effect of plummeting international markets. Presidents and political

leaders representing free-market policies and the waning of the state suddenly embraced ideas and policies traditionally known to be socialist to differing degrees: the guarantee of a basic income during furlough, single-payer universal healthcare coverage, subsidisation and strengthening of public services (water supply, electricity, telecommunications), credit cancellations or postponements to avoid debts with banks, stricter state control of public funds, reinforcement of taxation policies, and price regulation over the basic food basket, amongst others[8]. According to various world leaders, the pandemic revealed the need to maintain certain services outside of the market logic – mainly pensions, long-term care, healthcare services and public health systems. In a similar manner, regional leaders who refused to follow global public health recommendations, like the US and Brazilian presidents, have been profoundly ostracised by national and international media, and currently face the exponential toll of incidents and death-rates in their countries, yielding numbers higher than European registrations at their worst.

Albeit measures to alleviate the tension between public health and economy, the social chaos at a local level revealed that 'the context' was not fully captured in the global strategies that were applied. Another level of critical analysis was deemed necessary in light of the fatal failures of the state infrastructure to satisfy the needs of the population, the disproportionate impact of the pandemic upon social groups, and the struggles that public manifestations made clear in countries like Chile, Brazil and Venezuela. Rather than constitutional rights and freedoms, protests on the streets of Bogota and Santiago de Chile were driven by hunger and state abandonment. Multiple allegations of corruption tainted the solidarity efforts of governments, while dead bodies piled up on the streets of Guayaquil, funeral homes reportedly working beyond capacity in Mexico City, and Manaus began digging '*fosas comunes*' (common pits) – a term referring to mass burial grounds previously a grisly feature of wartime killings, but now used to express the drama of COVID.

[8] The neoliberal president of El Salvador, Nayib Bukele, directly confronted the accumulation of wealth by the elite class he represents during a public announcement of the quarantine measures. He stated: "There are entrepreneurs worried because they will be 10, 15 or 20% less rich today. Believe me, you have the money to live 10 or 20 lives" (Orbita TV, 2020). In an emotional call for national solidarity, the viralised intervention urged the higher economic sector to 'withstand the losses' for the sake of the majority, as they will be losing a fraction of their 'overflow' while others will lose even 'what they do not have' and face nights in hunger during the crisis. Despite the politics that placed Bukele in the presidency, his speech resembled more socialist rhetoric – though it was short-lived.

Image 7.2. A state of calamity: the digging of 'fosas comunes' on the outskirts of the city due to the collapse of funeral home at Managua, Brazil. Source: La Tercera, 2020.

Apocalyptic images on the news took place during the national lockdown, adding uncertainty and confusion to the government strategies that are supposed to be 'the only way to tackle the virus.' The reason for the tragedy of rising death-tolls and social chaos, however, were never integrated into the national pandemic response planning process. The naivety of local governments applying totalitarian measures, without a clear picture of what takes place on the ground, proves the deep ruptures and misalignments between state approaches and contextual realities. People across Latin America systematically broke government guidelines for a single reason: survival. Theirs have been decades-long struggles highlighted by social movements, popular strikes and public manifestation, systematically repressed and rendered invisible by a context of stigmatisation, oppression and marginalisation. The need for a different approach in how contemporary societies understand the relationship between health and society is clear, an approach that, instead of multiplying acritically the same vertical approaches in every country, considers the various elements and processes

specifically tailored to their circumstances. An approach to which the situated epistemology of Latin American social medicine contributes.

The COVID19 crisis across the globe brought critical perspectives on the marked disorganization of public health systems and the severe shortages of healthcare resources that both 'developed' and 'developing' countries of the world are facing (Gaudilliere and Beaudevin, 2020; Glassman et al., 2020; Zenco, 2020; Cash and Pattel, 2020; Dalglish, 2020). Comparisons have been made between the SARS-CoV2 pandemic and other health crises in western history, including the 'Spanish' Flu and the Bubonic Plague. The voices point at the paradoxical lack of preparedness across the globe, particularly from societies previously thought to be exemplary in the management of public affairs, but that were first and most strongly impacted by the pandemic during early periods of the disease. The reality depicted by the media echoed pandemic history, with a highly contagious disease sweeping through communities and authoritarian measures inevitably utilised to contain the invisible threat – that is, a threat made visible through facemasks, empty streets, and daily briefings. Within weeks of declaring the COVID pandemic, most countries adopted quarantine measures and lockdown policies that included closure of national borders, strict travel restrictions, curfews, prohibition of gatherings, isolation of high-risk neighbourhoods, groups and individuals, amongst others.

Despite advances in healthcare coverage, preventive approaches, medical technology and pharmaceuticals attributed to the dominance of biomedical reasoning, contemporary societies met striking limitations in matters pertaining to the safe-keeping population health at the most pressing time. Particularly, the lack of community engagement found in the authoritarian measures described above paints a picture of total 'divorce' between state institutions and everyday life (Horton, 2020; Ceron, 2020; Laterza and Romer, 2020; Breilh, 2020a). Instead of enabling closeness with vulnerable groups, the dominant political rhetoric across the globe focused on 'vertical' approaches including protective gear, development of vaccines, critical services in hospitals, and pharmaceuticals to severe cases. Daily news fed the loop of excluding the local context, providing insights from high-level institutions on the virulence of the Coronavirus, the multiple modes of transmission, the mechanism of pathogenesis, the genetic structure of the pathogen, new protocols for protection both inside and outside health institutions, etc. Technical information and expert knowledge now flood common-sense, making clear information hard to follow and crafting mayhem

in the most vulnerable (and less educated) sectors of society. It is as though global leaders remain convinced that, by applying the same mindset characteristic of our most recent scientific history, contemporary societies will somehow obtain different results to the conditions we now live.

Undoubtedly, as a medical doctor, I am convinced that vertical approaches are helpful and required in the present circumstances. However, the disproportionate emphasis on the technical approaches mentioned above obscures a fundamental feature of contemporary western societies that the COVID19 pandemic laid bare: context matters. By blurring the differences in social structures and processes between and within countries (which the pandemic has arguably done by reproducing similar approaches across the globe), the attention required for necessary changes in western society is deviated towards deepening the same epistemological approaches that contributed to the lack of preparedness for the pandemic in the first place. For various local organisations worldwide, including ALAMES, societies need to transform dominant ways of conceiving health to dismantle the downgrading of local epistemologies and vindicate effective knowledge that articulates with indexical features of the context.

Likewise, taking seriously the situated ways of thinking the local socioeconomic, political and cultural process of the context blurs the artificial North-South division commonly found in global health literature. To be clear, the 'Global North' is linked to capitalist societies enjoying exceptional status, resulting from the historical application of comprehensive rights, policies of social management, socialisation of costs, universalisation of social benefits, and cooperation in science and technology. Contrasting the abundance of the North, 'the Global South' constitutes the bundle of so-called developing countries, which rely on charitable philanthropies and depend on the 'central' economies of the capitalist hierarchy to progress towards the 'development' that powerful countries claim to possess. The South, therefore, struggles with the fulfilment of essential needs, the optimal management of resources, and the autonomous constitution of local expertise. The division between global north and south creates an asymmetry reflected on the power countries have at the level of political, social, cultural and financial engagement.

Despite the fruitfulness that the division above has had in political and academic domains, the pandemic brought together the asymmetry by making evident that the struggles, challenges and approaches in both territories of the world are strikingly similar. Many areas of the so-called 'north'

are facing the same difficulties that were thought to be particular of the 'south,' revealing that health is governed by 'inequalities within countries' more notably than the divide between developed and developing regions (Ferguson, 2006). The same inequalities, social irregularities, and structural injustices that prompt mass protests and sharp civil disobedience are witnessed in most western liberal countries regardless of their level of 'development.' The case is set, therefore, to cease thinking about global health through the lenses of the artificial North-South divide and focus instead on the underlying epistemology which permeates contemporary way of reasoning health across the western world. That is to say, attention ought to be placed on the type of epistemology that seems to disregard the specificities of local history, the situated experiences of people, and the particular contingencies of the context. The Latin American case on COVID19 illustrates the case further.

Despite the goal of 'flattening the curve', various publications have made evident the limitations of Latin America's vertical policies, highlighting concerns over health inequities, the persistent vulnerabilities of healthcare systems, and the reproduction of a way of thinking about health that mismatches the real needs of the most vulnerable population (Ortega and Behague, 2020; Irons, 2020; Guimarães, 2020). According to Castro (2020), for instance, governments often overlook the differential impact COVID19 has had on urban and rural areas, managing both territories in striking similar ways. In most major cities across the region, the first cases of the disease were reported as 'imported' by travellers arriving from abroad, belonging to well-off sectors of society. By the time lockdown measures were enacted, most of these first cases and the higher spectrum of the social hierarchy complied reasonably well with the restrictions, many continuing their work remotely at the comfortableness of their homes and awaiting the next delivery from their weekly online shopping.

The distribution of the disease, however, progressively moved towards marginalised areas as 'the fundamental workforce' acquired the disease during their everyday tasks, enabling the quick spread of the virus among their communities. Rather than an issue of personal responsibility for 'not keeping with the restrictions,' as many governmental authorities argued (to the indignation of many), the exponential growth of registered cases was associated to the dire conditions of living at the local level. Conditions such as lack of sanitation, poor housing infrastructure, overcrowding, and limited financial resources among families clearly differentiated the new and most relevant spread

of the virus from the original cases. Given that the impact of the pandemic was disproportionately distributed in undocumented ways, the nationwide quarantine measures did not deliver the expected results – a reality overwhelmingly ignored by national authorities (Radcliff Institute, 2020; Harvard, 2020; Krieger, 2020). In the most deprived neighbourhoods, confinement was seldomly obeyed because people were forced to leave their homes to find any means of sustenance (*Oxford Department of International Development*, 2020). The decontextualised lockdown policies, a Latin American activist explained, were devised for the upper-class society – while the working-class and agricultural sector were treated like 'disposable bodies' unable to keep up with the times (ALAMES, 2020a).

The myth of COVID19 as a great 'equaliser' was quickly dismissed by the greater exposure of hospital staff, nurses, care-home workers, shopkeepers, bus drivers, police, fire-fighters, and other lower-paid labourers who were unable to work from home. This reality made the reasoning, practices and language around the pandemic misleading, trite and recalcitrant. Indeed, staying at home is currently not an option for the 12.6% of unemployed citizens or the 5.7 million informal workers in precarious conditions within Colombia who were suddenly left short of savings and without financial means. Nor is it possible for the farmer who lives off selling products in the local markets that no longer exist and are left to fend off with their products on the main roads. Thirteen million Colombians who are registered below the poverty line cannot 'reinvent' themselves or 'pull-out' strength from their character to find ways to subsist. They are not disregarding advice through behavioural deviance, nor can experts assume their greater susceptibility is an issue of genetic or biological determinism. Instead, cases point to a necessary and more profound analysis of the societal structure and situated context in which they live. Most importantly, the disparities that the COVID19 make evident also calls for tailored approaches rather than the one-size-fits-all.

Additionally, rural areas and Indigenous communities across the region don't experience the same social conditions as cities but face a different set of vulnerabilities that are characteristic of state abandonment, *guerrilla* or paramilitary violence, and geographic isolation. These vulnerabilities include the inadequate access to healthcare services and resources, frequent food shortages, lack of drinkable water, forced migration, etc. The lockdown policies have brought about more awareness in other neglected problems within these territories: gender violence in rural homes increased as confinement left women more vulnerable to abusive partners, discrimination of

minorities at state institutions is more evident, and the death-toll of community leaders is swelling given that the restriction of movement makes individuals an easier target to illegal armed groups. Despite the complexity of the context, the priority of government measures remains the fulfilment of the quarantine and the use of facemasks. Rather than heeding attention to the structural injustices, violence and increased vulnerability; state policies disregard the dialogue with underprivileged perspectives and seem to rely on the totalising interpretation of the pandemic set by biomedical expertise. In so doing, the message heard by vulnerable communities, who are already sceptical of governmental intervention, is that the state renders their standpoint less worthy and reproduces the colonial rhetoric of Latin American history (ALAMES, 2020a, b, c).

The pandemic also revealed the realities of middle-class families in Latin America who tend to disappear in the competitive market of capitalist life amidst the quarantine chaos. Labelled 'hidden poverty in the middle-class' (El Espectador, 2019; SIS, 2019; El Tiempo, 2019), the category corresponds to social groups living in sectors of Bogota DC.. traditionally known to be part of the 'better' social class, but which have become a rising source of concern for government administrations and researchers. According to various sources (El Tiempo, 2020; CdB, 2019; El Poder, 2020), these groups are characteristic for having outstanding vulnerability to fall into poverty following a societal crisis, given their current living circumstances including lack of savings, accumulating debt, no ownership of assets, precarious labour conditions (hourly-based contracts with no social protection, or informal work with long-term uncertainty), no social protection nets, amongst others. Their resilience to endure harsh conditions is, therefore, very limited. However, given that the location of their residences does not fall within the territories liable to financial aid by the government (El Pais, 2018), their vulnerability is often rendered invisible or neglected.

The pandemic changed the face of the 'hidden poverty' by turning its vulnerability into a harsh reality. The stagnant economy, lack of opportunities and exponential growth of unemployment rates have left these families unable to fulfil basic needs, pay the rent, cover social services, send their children to school, etc. In attempts to capture the drama these groups now experience, the media renamed the social group 'los sin techo de la clase media' (the 'non-roof owners of the middle-class' in Semana, 2020a, b; see also Dinero, 2020). Despite the contingency plans set up by governments during the current 'state of emergency', the limited state infrastructure and lack of robust tax-policies leave public administrations unable to assist further, and families abandoned to

their own affairs (CdB, 2020). To date, there is no surveillance system in the continent comprehensively documenting the current state of these families, that is, no official data is gathered on the reality and/or narrative of those suffering (Breilh, 2020a).

Despite the efficacy these measures show at the local level, similar approaches of community engagement are not amply supported (let alone regarded) as part of the COVID19 measures by most regional governments. The cases above expose the rupture between vertical measures and grassroots initiatives not merely as an issue of unaddressed social conditions, but also as the particular and dominant way in which western societies fail to consider the inclusion of local action, positioned knowledge and situated epistemologies. That is to say, the evidence above raises concerns over the public health epistemology being applied in the pandemic. By expanding the disciplinary boundaries of health to consider the economic, political and cultural spheres of everyday life; expert biomedical knowledge ceases to have exclusive value and becomes one more source of information among a myriad of perspectives. The COVID19 pandemic has made evident the arbitrariness and inadequacy of the imagined boundaries between 'the social' and 'the biological,' the medical sciences and 'the rest', as well as the misinterpretation of the social basis of health. COVID19 has generated a call across the world to render clear-cut boundaries in studies, practices and policymaking obsolete by instead considering the dynamic relations and processes in which health develops.

Research models that *decontextualise* health processes – separating health data from the systems of oppression, social symmetries and structural injustices – have lost their traction. The mere adaptation of general approaches to specific context do not seem to suffice anymore, prompting the need to take seriously alternative understanding of health within public health institutions, civil society groups, and medical practices. The nature of population health calls for the integration of situated knowledge and practices, with new approaches that enable engagement with context-sensitive perspectives, subjugated standpoints, and narratives from local struggles. The goal proposed by ALAMES as a situated epistemology is to *recontextualise* the understanding of health and disease, to match health-related analysis to the immediate realities of people, to ground political action on the claims and vindications of social struggles, and to radically transform health epistemology into a plurality of viewpoints.

Throughout this thesis, the ALAMES collective has shown a profound scepticism on contemporary attempts to transcend the situatedness of local knowledge and experiences by appealing to ideas of universality and objectivity. The work of the thought style yielded how different understandings of objectivity can operate within a social medicine agenda. Rather than interpreting population health in biological terms alone, features like the Social Determination model and the pluralism in health knowledge challenge the superior status of biomedical knowledge (or vertical approaches), and invite the reintegration of the social basis of health and disease to the COVID crisis. Latin American social medicine recognises that the situatedness of a thought style yields various perspectives stemming from diverse social struggles that require the integration of different forms of embodied oppression, injustices and domination. With this redefinition from the ALAMES situated epistemology, objectivity becomes the aggregation of multiple truth-claims from which reality is constructed far more comprehensively.

The integration of multiple knowledge from diverse groups coming together also transforms the dynamics of the COVID crisis, reconfiguring the way ALAMES militancy is enacted by the collective health movement. From social activism, public manifestations, protests and academic events; ALAMES has moved to open engagement via social media and streaming services – that is to say, more efficient avenues for connectivity. Since March 2020, the association delved into Facebook, Twitter, YouTube and Zoom in unprecedented ways, promoting two strategies that aim to diffuse the thought style amidst the current difficulties. Firstly, the General Coordination has coupled with the Dominican Republic national chapter for a cycle of virtual conferences in preparation for the XVI ALAMES International Conference that plans to take place in Santo Domingo in November of 2020. Under normal circumstances, each national chapter promotes the conference through local events, discussing the main themes of the conference. Things have now changed. With the new virtual dynamic, ALAMES has gain remarkable notoriety unmatched by any previous attempt to reach the broader population. The invitation to virtual forums is extended to any person who wants to join, and led by ALAMES most renowned leaders, covering topics such as social movements in times of COVID, and the management of health information during the chaos.

Secondly, the ALAMES national chapters are meeting informally every fortnight via Zoom, with the theme ‘ALAMES Dialogues on COVID.’ This is meant to draw all of the association’s members for a discussion of the realities in their local context, providing a diagnosis, evaluation, and analysis to

construct a course of action. So far, six meetings have taken place that have reignited the collective's commitment to the SUS model as explored in chapter six, and the multiple ways through which the Social Determination model can be integrated into medical curriculums, health research and public health centres. Among the multiple topics discussed, a few take particular priority, given the pressing realities of the collective on the ground.

On the one hand, ALAMES members report the recurrent mismanagement of the pandemic by public authorities justified by the depolitisation of the disease. As explained above, the focus of most Latin American governments is the technical aspects of COVID-19 including virulence, testing, vaccinations, ICUs, etc. By disregarding underlying social processes in health, ALAMES members argue that governments are taking advantage of the one-size-fits-all discourse, using the pandemic as a mechanism to acquire unwarranted political power that would not be possible under normal democratic conditions. Governments in the region have declared 'states of emergency', protected by the constitution and supported by public health authorities. As a result, states are militarising cities in ways that resemble the strictest authoritarian regimes in Latin America's history.

Shielded by the lockdown policies, the militarisation has become another strategy of social control that keeps social movements and popular protest at bay. ALAMES General Coordinator, Emira Imaña, and Bolivia representative, Vivian Camacho, both argue that the current 'coup regime' of right-wing interim president Jeanine Añez is taking advantage of the extrajudicial faculties left by the pandemic to 'silence,' 'block' and 'repress' the opposition movement. Similar allegations have been made by representatives from ALAMES Paraguay, Ecuador and El Salvador. The extraordinary acts granted by these governments have been seen as enablers of new agreements and loans with the World Bank and International Monetary Fund for secondary financial gain. These allegations refer to new deals that lack public accountability or social oversight, echoing the wave of 'silent reforms' of the neoliberal policies during the 1990s in Latin America (Jasso-Aguilar et al., 2004; Iriart et al., 2011).

On the other hand, the ALAMES dialogues on COVID have expressed mistrust of the official data released by various governments in Latin America. In essence, the association's representatives argue that due to the neoliberal systematic budget cuts to the national surveillance system or public health programmes, most of these countries have poor infrastructure to guarantee that the

information is not only driven by numbers, but also by public participation. At the third virtual conference on health information by ALAMES (ALAMES, 2020g; see also 2020c), various members of the collective underscored the lack of information on the pandemic 'in real time' that could disaggregate data on the basis of socioeconomic status, gender, ethnicity, urban vs rural location, etc. The flawed information system obscures rampant health inequities and growing social disparities in the region, supporting the case that such structural issues had been normalized in Latin American politics for years. Through the pandemic, disparities within the population seem to have emerged as central for political debates. Nevertheless, the thrust of the debate has little or no effectiveness at the national level due to the lack of information to engage in critical analysis and propose adequate resolution. The faulty response from governmental authorities lead various ALAMES representatives to conceive the misinformation above as arising from a lack of dialogue between the government and local collectives (who are vigorously highlighting the reality on the ground).

ALAMES representatives from Nicaragua, for example, reported the total absence of President Daniel Ortega for over a month during the COVID crisis, with information emerging exclusively from the aggregation of data produced by non-governmental organizations dispersed throughout the country (rather than officially by the government). ALAMES Brazil highlighted the conflict between the denialist federal government of Jair Bolsonaro, who replaced several Health Ministers in a matter of weeks. State leaders in areas like Rio de Janeiro were taking the pandemic seriously, yielding different data on each side but clashing with the claims, mandates and evidence presented at the federal level. And ALAMES Chile joined the conversation on misinformation of COVID19 with the recent resignation of Jaime Mañalich, the Piñera government's Health Minister, due to the strong controversy over a report revealing that the Chilean Department of Statistics delivered different numbers on COVID19 mortality to the WHO compared to the data presented to the general public (DW, 2020b; BBC, 2020). The differential data was presumably meant to hide the real burden of the pandemic in Chile, to give voters the appearance that the governmental management of the crisis has been optimal.

The collective points at the clear dissociation and disarticulation between the 'global' public health approaches vs the 'local' reality of people on the ground. The former refers to the vertical measures during quarantine and the race to discover biomedical solution. While the latter refers to the health

inequities and social disparities, which places the populations of Latin America at a greater risk and challenges the pandemic as a 'global equalizer.' ALAMES General Coordinator, Eduardo Espinosa, explained that both the COVID pandemic and the profound disarticulation above are not random, but result from the 'crisis of civilisation' as conceived by the collective.

Looking ahead to the post-COVID world, social medicine questions the arbitrary boundaries that disarticulate the 'local' and the 'global' so profoundly, and that emerges from the 'civilising project' or fundamental epistemology of western exclusivism. Throughout discussions about the pandemic, ALAMES representatives point to the colonial heritage of Latin American history as the root cause that crafted an omnipresent social hierarchy that justifies the superiority of 'global' approaches at the expense of the 'local', disregarding and rendering invisible the contextual knowledge and situated claims of struggles. In creating this hierarchy, different sectors of the Latin American elite argue for the subordination of the 'local' to universalising claims from epistemologies like biomedicine, conferring inferior value to anything emerging from the context. The exclusion is directed to subaltern groups traditionally marginalised in the region, including Indigenous communities, agricultural collectives, women's groups, Afro-American descendants, rural communities, lower social classes, etc.

As explained in chapters three and four, these collectives and their situated experiences precisely form the social basis for ALAMES and represents the driving force of Latin American social medicine. Consequently, the collective has stressed the relevance of constructing knowledge based on the partiality, contingency, instability, contestability and differential positions that grounded standpoints offer. The world post-COVID, according to various ALAMES representatives, requires accountability and critical analysis on the assumptions found in the 'global' approaches for the sake of imagining alternatives that are more relevant at a local level, and for historically subordinated collectives. Likewise, ALAMES rejects any self-proclaimed 'unified theory' that attempts to capture the whole truth from one totalising standpoint or metanarrative – either coming from any local knowledge or from the universalising sciences like biomedicine. The crux of the matter, therefore, does not lie in the truth of any given thought style, but on the unfounded exclusivism conferred on any given truth-claim.

As expanded in the ALAMES pluralism of knowledge, the goal is the co-existence of biomedicine with other forms of situated epistemologies, aimed at evidence-based impact on population health. The social medicine collective advocates for equal standing on both dominant and non-dominant ways of reasoning health and disease, enabling the evaluation of its pertinence to a particular object of study and political objective. Additionally, Latin American social medicine is merely one embodied view that corresponds to the experiences and critical reflection of the regional context – and cannot be equated to the situated standpoints in other regions that experience power asymmetries, systematic oppression and structural injustices. In the analysis of social irregularities, 'context' is not an overarching or unified term, but imperfect and accountable to the multiple voices, a shifting plurality in search of an adequate analytical focus according to the context, needs and requirements. There is, moreover, no single standpoint that captures the complexity of contexts across the globe. Rather, the ALAMES collective remains open to a dialogue in health epistemology that integrates multiple views, local and global, and that may ultimately contribute richer insights into global health concerns.

The discussion on the COVID19 crisis within ALAMES has not expanded the underlying causes that explain the lack of preparedness and overwhelming shortages found in the Latin American societies. The root cause of the public health collapse is not recent nor cyclical, but rather results from ongoing structural conditions that predisposed the national infrastructure to immense vulnerability in the face of a crisis or pandemic. As expanded in chapter five, the social medicine collective recognises that the neoliberal wave of reforms and the systematic application of austerity measures in Latin America generated ever-growing budget cuts on public services, including nursing homes, the public healthcare system, and pension scheme. The wave of reforms and policies set the stage for a crumbling of public services, and artificially constructed the need to incorporate private actors to sustain services, that enabled the intersection of for-profit interests into decision-making process over public funds and collective needs. There rests a possible line of arguments that shed lights into the root cause of the poor preparedness countries now face (and yet, it has not been done in ALAMES). At the global level, the mismanagement of risk preparedness echoes the history of global health governance. Different factors such as the increasing international debts, political attacks against intergovernmental strategies at the UN or WHO by Reagan-Thatcher ideology, and the HIV/AIDS crisis, demanded an increased in disease-based programmes (Gaudilliere and Beaudevin,

2020). This also handed the health field to private actors, driven by cost-effective analysis and favouring vertical approaches instead of strengthening the public health of vulnerable states.

Another potential strength offered by the ALAMES collective for the post-COVID world is the incorporation of a SUS model in the healthcare system as a matter of 'right to health' – an approach that considers public participation, and the strengthening of national infrastructure. The dual purposes of Latin American social medicine in the SUS include: (i) the state provision of a publicly-funded, unified, universal coverage healthcare system that abolishes any financial obstacle at the point of services, and is driven by the best evidence possible on the field, and (ii) the action upon the social determinations processes through the 'democratisation of health', that incorporates social movements, collectives and communities into decision-making processes around healthcare services and broader social affairs. Lastly, calls have been made within the collective to systematise the so-called 'monitoreo critico en salud' (critical health monitoring in ALAMES, 2020d), consisting on the active engagement with social movements and/or local collectives for the recollection of data that constitutes a contextually-grounded epidemiological surveillance system. The endeavour is already being advance in countries like Colombia where, in order to acquire a more comprehensive evaluation on the impact COVID-19 has had on healthcare professionals in Bogota DC, ALAMES members work together with syndicates, healthcare associations, and independent groups to construct the local data base. The system has the potential to extend beyond the analysis provided by the local government, since the data includes information on gender differences, type of labour, it captures narratives by health professionals themselves, amongst other elements.

The next challenge on the social medicine agenda, therefore, is to cease being an alternative approach to dominant approaches, and to become an integral component of the health epistemology, both at the academic level and the political milieu. Latin American social medicine has not yet made the jump to transform medical pedagogy as developed in mainstream programmes of public health, health economics, public policy, philosophy of medicine, clinical specialties, among others. The goal for the post-COVID world is to diversify the contemporary understanding of health and its relationship with society, integrating the interdisciplinary, multidimensional and emancipatory foundations of social medicine.

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